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ABSTRACT

The Enterprise Zone-Preschool Inclusion Project (EZ-PIP) was a four-year demonstration project funded by the U.S. Department of Education, Office of Special Education Programs. The purpose of the project was to expand, implement, evaluate and disseminate a model program designed to promote the inclusion of young children with disabilities into early childcare programs in economically depressed areas of a major metropolitan city. The model included three components, which are detailed in this manual: training; technical assistance by special instruction consultants; and mentoring. Book 1 of the manual consists of the curriculum used to train childcare staff regarding children with disabilities and how to include these children successfully in their childcare settings. Book 2 describes the technical assistance component of the project and includes a description of the role of the special instruction consultant, sample case studies, lists of concerns and strategies, a copy of the Children Medical Services (CMS)/Special Instruction Consultant Standards, and a technical assistance resource manual. Book 3 describes the mentoring component of the project and includes a sample mentor application package and a mentoring training program. Book 4 presents the findings and accomplishments of the project. (SG)

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The Enterprise Zone-
Preschool Inclusion Project

A Training and Resource Manual for Inclusion in Childcare

Book 1: Curriculum

[and]

Book 2: Technical Assistance

[and]

Book 3: Mentoring Components

[and]

Book 4: Findings and Accomplishments

University of Miami
School of Medicine
Mailman Center for Child Development
Miami, Florida

Susan Gold, Ed.D., Principal Investigator

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The Enterprise Zone-Preschool Inclusion Project

A Training and Resource Manual for Inclusion in Childcare

Book 1: Curriculum

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A helpful tool for Early Care & Educational Professionals

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The Enterprise Zone-Preschool Inclusion Project

A Training and Resource Manual for Inclusion in Childcare

University of Miami

School of Medicine
Mailman Center for Child Development
Miami, Florida

Susan Gold, Ed.D., Principal Investigator

The Enterprise-Zone Preschool Inclusion Project was funded by
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#H024B70071

Book 1: CURRICULUM

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Introduction

This manual is intended to assist trainers and administrators in the development and implementation of inclusionary programs for childcare centers in their communities. The manual includes information on training regarding disabilities, typical development and inclusion, how to develop a successful mentor program, providing technical assistance, locating resource and referral process information.

The Enterprise Zone-Preschool Inclusion Project (EZ-PIP) was a four-year demonstration project awarded to University of Miami/Mailman Center for Child Development by the U.S. Department of Education Office of Special Education Programs. The purpose of the project was to expand, implement, evaluate and disseminate a model program that would promote inclusion of young children with disabilities into early childcare programs in economically depressed areas of a major metropolitan city. The model included three components, which are detailed in this manual: training, technical assistance by special instruction consultants, and mentoring. The manual also includes a section on outcomes and conclusions.

The project was begun with three assumptions. First we believe that inclusion is beneficial for young children and their families. Secondly, we know that awareness and knowledge of inclusionary practices continues to expand, therefore we made every attempt to provide up to date information and research findings. Our final assumption is that inclusive programs have varying rates of effectiveness, based on quality of the program, support to staff, and involvement of families. The three components of the model were meant to address these variables.

EZ-PIP targeted childcare programs in low-income areas, or Enterprise Zones as they were called in our community. These zones include minority children and children with limited English proficiency. The need for high quality childcare settings that will include young children with disabilities is especially pronounced in chronically economically depressed communities. In order to ensure cultural responsiveness we chose project personnel from a wide range of ethnic, linguistic and cultural backgrounds. We provided the training sessions, mentoring and technical assistance in the home language of the providers whenever possible, and adapted materials to reflect the cultural background of the children and childcare staff. Our aim was to provide a model that could be implemented in other parts of the country with similar rural and urban communities.

The Mailman Center for Child Development at the University of Miami School of Medicine is committed to supporting young children with disabilities and their families, with improved and expanded services. Although federal law mandates the provision of childcare in the natural and least restrictive environment, it is still underutilized as an option in many communities. This project responded to a unique window of opportunity to serve a large number of children with disabilities and their families by providing them expanded choices for quality childcare. The Enterprise Zone Preschool Inclusion Project is committed to the belief that successful inclusion, for all children with disabilities, is achieved one child, one site, and one attitude at a time. It is our hope that this manual will assist other communities in developing their own projects that will expand the opportunities for young children with disabilities and their families.

Objectives:

1. Expand the number of inclusive family childcare homes and childcare centers in Enterprise Zones
2. Increase the number of children with disabilities who attend quality inclusive childcare settings
3. Increase the awareness and competencies of child care providers to serve children with disabilities by providing group and individual training and mentoring
4. Increase individualized educational services and assessments for children with disabilities
5. Facilitate cooperation between the systems of service delivery for children with disabilities

Strategies:

1. Provide specialized up to date training for childcare providers in both family childcare and center based settings
2. Provide peer mentors for trainees
3. Provide comprehensive screenings at multiple time points and document the developmental progress of children with disabilities
4. Provide technical assistance with the development and implementation of Individual Family Service Plans and Individualized Educational Plans through the special instruction consultant service
5. Provide support and education for parents of children with special needs and encourage parent participation in classrooms and meetings through the special instruction consultant service
6. Utilize the special instruction consultants to increase cooperation between existing systems of service delivery

Book 1: Training

Curriculum Overview

The objective of the training was to increase the awareness and knowledge of childcare staff regarding children with disabilities, and how to successfully include these children in their childcare settings. Much of the training was adapted from the Model of Interdisciplinary Training for Children with Handicaps (MITCH)[1] Modules, which was developed in 1989 by a grant awarded to Miami-Dade County Public Schools, Florida Diagnostic and Learning Resources System - South (FDLRS). These modules are currently being revised as the Grow-to-Five Series and they are available from the Clearinghouse Information Center, Bureau of Instructional Support and Community Services, Division of Public Schools and Community Education at the Florida Department of Education, Room 614 Turlington Bldg, Tallahassee, Florida 32399-0400 (see Resources for more information).

The sessions in this training are two hours long and can be easily expanded to 3 hours. The trainer has the flexibility to modify training sessions to meet the needs of the students. With the exception of session I, the training sessions can be rearranged and implemented, as the trainer deems appropriate to fit the needs of the participants. Our trainings occurred twice a month at selected sites. Each session was filled with activities, videos, and reading materials to promote maximum learning. The sessions include the following topics:

- Introduction to the Philosophy of inclusion
- Early Brain Development
- Screening Young Children in the Classroom Setting*
- The Child Who Seems Different

- Developmentally Appropriate Practices and Adapting the Classroom for Children with Special Needs
- Behavior Management
- Intellectual Development: What You Can Do To Help
- Speech and Language Development*
- Health Care: Infection Control, Medication Administration and Seizure Management*
- Working Together: Communication and Teamwork in Caregiving Setting
- Professionalism and Advocacy

* Professionals from the respective field may present these sessions, for example a school psychologist, speech pathologist, and nurse.

Attendance at each session was required and certificates were awarded after satisfactory completion of written assignments for each workshop. We completed each training series in approximately eight months, with classroom and child assessments occurring before and after the series. However this program can be adapted to fit the individual needs of each community and may take more or less time to complete.

*** IMPORTANT NOTE: The main facilitator/trainer must believe in the benefits of inclusion of young children with special needs. As in all learning environments, the trainer must be charismatic and persuasive.

Most participants are childcare providers who did not intend to work with children with disabilities and now find that this is becoming commonplace. The participants are facing issues of resentment and fear. The trainer must be able to discuss such issues in a positive manner while acknowledging the feelings of the participants.

Recruiting Participants

Before preparing to recruit participants, it is important to define your target audience. Will you be working with caregivers in a specific geographic area such as an Enterprise Zone? Will you train primarily with caregivers from child care centers or from family child care homes? Have any potential participants approached you and indicated a need for training in working with children with special needs, or will you be raising awareness for the need for inclusive care? All of these questions should be considered prior to initiating the recruitment.

Once you have defined your target audience you can begin to look for participants. One way to find people who are interested in this training is to contact your local childcare resource and referral agency and ask if they have a regular directors' meeting. If they do, ask if it would be possible for you to make a presentation at directors' meeting or to distribute information and interest surveys. If there is no directors' meeting, there may be a directors' support group or a meeting of members from an early childhood professional group. Check with the National Association for the Education of Young Children (NAEYC) to see if there is a local affiliate organization. It is important when presenting this training to have the support and guidance of the directors of the centers. You may also want to contact the educational departments of local community colleges or vocational/technical schools that have childcare programs in their curriculum. If you are in a small community you may want to just call or stop by childcare centers in the area and talk to the directors in person. It is better to recruit too many potential training participants than too few, as it is sometimes difficult to retain all participants for the entire training series.

After you have a group of interested participants you will need to decide where and when the training sessions will be held. Many childcare center directors prefer on-site training, but unless you have an unlimited number of trainers, you will probably need to pick one central location and have some participants travel to that location. We had some success in providing substitute reimbursement to directors who permitted their teachers to attend training off-site. Regarding the location of the training sessions it is important to remain flexible while maintaining professional standards. For instance, a classroom setting with adult sized tables and chairs, and audiovisual equipment is ideal. However, we have held training sessions is church meeting rooms, in staff lunchrooms, and even in children's classrooms. There may be distractions and it is important to keep a sense of humor and a good attitude. Owner/operators of family childcare homes frequently request training sessions to be held in the evenings or on weekends at their homes. Survey the participants in person, by telephone or mail to find out the best time of day, the best location, the day of the week and the frequency of sessions. (See attached survey). This will vary with each group. Participants from childcare centers often preferred naptime, as this was the easiest time to permit people to leave the classroom. Some groups preferred weekly or bi-weekly training while others preferred monthly sessions. Training during the middle of the week was often more effective than training on Mondays or Fridays as it was more likely that participants would remember to attend. Keeping participants' needs in mind will assist you in retaining training participants.

After finding your applicants and deciding together on the training schedule, it is helpful to distribute the schedule to all participants. This can be accomplished by email, fax, or mail but it is important that everyone gets a written copy of the schedule. Participants should be notified of any changes in the schedule. Additionally, it is helpful to follow up with a phone call or fax reminder the day before each training session or the morning of the session. This helps increase attendance rates.

To increase the retention rate once participants start attending the sessions we have found the following techniques to be helpful.

✓ **Provide refreshments.** If your budget does not allow for this expense get creative! Ask if the participants can share the responsibility of bringing snacks and drinks, contact a local grocery store or restaurant and ask if they would be willing to donate food, or ask the directors if they have a budget for refreshments. Food motivates people!

- ✓ **Provide prizes.** Again, be creative in budgeting for this. Something as simple as a candle or bubble bath can make the training seem more personal and special. Materials such as low cost videos, pamphlets and brochures, small toys and other items related to the training session will help people retain information and keep them coming back for more.
- ✓ **Recognize accomplishments.** Let participants know in the beginning of the training series that they will receive a certificate of completion if they attend a certain number of sessions. Give certificates of attendance to participants for the number of sessions they attend. Many employers require attendance at in-service training and a written document fulfills this requirement.
- ✓ **Thank participants for coming.** Acknowledge that they may be tired, that they may be giving up their lunch breaks or personal time to attend the sessions. Let them know how much you appreciate their attendance and their valuable time.
- ✓ **Form positive relationships.** Make it a point to find out about the participants. If possible, visit their classrooms or family childcare homes. Give them your telephone number so they can call if they have specific questions.

✓ **Have realistic expectations.** Accept that every single participant will probably not stay interested and involved one hundred percent of the time. Accept that some participants may only attend one or two sessions and that someone may occasionally fall asleep. Focus on the positive and realize that the information you are conveying is important. If even one person "gets it" and makes a difference in the life of a child, it is worthwhile.

✓ **Learn about your participants.** Find out their educational levels, their experience, how many have worked with children with special needs. You may have experts in the sessions who can answer questions and be resources to other participants.

The Enterprise Zone-Preschool Inclusion Project

Sample Forms

EZ-PIP

Date ______________
Session # __________
Session Title _________
Location ____________
Trainer _____________

Sign In

Name (please print)	Center

EVALUATION FORM

Today's Date: ______________

Position: ________________

Please rate the following aspects of this session by circling the appropriate number.

Purpose and Goals	1 Not Realized	2		4	5 Completely Realized
Interest Level	1 Very Low	2	3	4	5 Very High
Clarity of Presentation	1 Vague Confusing	2	3	4	5 Clear, Concise
Information Received	1 Irrelevant, Meager	2	3	4	5 Relevant, Useful
Instructor's Approach	1 Dull	2	3	4	5 Imaginative
Materials	1 Poor	2	3	4	5 Outstanding

Please answer all the following questions clearly.

1. How has the training content been helpful? Do you see it having any value to you in your training?
____
____

2. What changes would you make in the training session content and organization?
____
____

3. Which activities did you like the **MOST**? ______________________
____

4. Which activities did you enjoy the **LEAST**? ______________________
____

THANK YOU FOR YOUR INPUT!

University of Miami's Mailman Center for Child Development's
Enterprise Zone-Preschool Inclusion Project/CCC

Child Development Center Director's Response Form

Print your 6-digit **ID Number** here (first name and last name initials plus the last four digits of your social security number): ___ ___ - ___ ___ ___ ___

Name of Center: ______________________________ HRS/CFS License No. __________

Address: ______________________________ City __________ State ____ Zip ________

Telephone (w/area code) _____ - _____ - ______ FAX _____ - _____ - ______

1. **Staff Composition** (check applicable positions and specify number in each category)

a. Center Director #____
b. Assistant Center Director(s) #____
c. Curriculum Specialist(s) #____
d. Head Teacher(s) #____
e. Teacher(s) #____
f. Teacher Assistant(s) #____
g. Teacher Aide(s) #____
h. Other (please specify)__________ #____
i. Other (please specify) ________ #____
j. Other (please specify) __________ #____

Total Number of Staff:________

2. Please list your **hours of operation**:

a. Weekdays: Monday-Friday ____:____ a.m. to ____:____ p.m.
b. Evenings: ____:____ p.m. to ____:____ p.m. or a.m. (circle one)
c. Weekends: Saturday ____:____ a.m. to ____:____ p.m.
Sunday ____:____ a.m. to ____:____ p.m.

Total Hours of Operation Per Week:________

3. Is your Center currently **accredited**? ____Yes ____No If yes, by whom? ____NAEYC ____FISA

____Other (please specify):______________________________________

4. Inclusion staff development sessions need to be conducted in the following languages:

a. ____English
b. ____Spanish
c. ____ Haitian Creole
d. ____Other (please specify) __________

5. **Enrollment Composition** (please specify number of children in each category)

a. Birth to 12 mos. #_____
b. 13 mos.-24 mos. #_____
c. 2 years #_____
d. 3 years #_____
e. 4 years # _____
f. 5 years (Pre-K) #_____
g. Other (please specify) _________ #_____
h. Other (please specify) ___________ #_____

Total Enrollment:__________

6. How many families are enrolled in your center? #__________

7. How many families would or do qualify for state or federal subsidies for low-income families? #__________

8. Please check and list how many children you have enrolled in the following ethnic groups?

a. African American #______
b. Haitian/Haitian American #_____
c. Hispanic #_____
d . Native America #_____
e. Asian/Pacific Islander #_____
f. Non-Hispanic White #_____
g. Bi-racial (please specify ethnic groups and number):
(1)_________________ #_____
(2)_________________ #_____
(3)_________________ #_____
h. Other (please specify ethnic group and number):
(1)_________________ #_____
(2)_________________ #_____
(3)_________________ #_____
(4)_________________ #_____

9. Does your center accept children with known disabilities or special needs? ___Yes ___No If no, please explain why not: ____

____

10. How many children enrolled have been formally diagnosed with a disability? #_____

11. How many children enrolled do you suspect have a disability or special need and have not been formally diagnosed? #_____

12. Does your center have a policy or procedure for identifying children with disabilities? ___Yes ___No. If yes, what is the position/title of the person who is responsible for

a. Identifying the children? ________________________________

b. Talking with the parents? ________________________________

13. Does anyone at your Center administer tests or measures to screen for developmental delays? ___Yes ___ No

14. Briefly describe how you would (do) work with children who are at risk for developmental delays.

____

____

15. Briefly describe how you would (do) work with a child with special needs (a handicapping condition).

____

____

16. Describe the steps you would take if a staff member thought a child were not developing appropriately?

a.____

b.____

c.____

17. Do you currently have a staff development program? ___Yes ___No If yes, what topics are covered, who conducts the program and where does the program take place?

a. Topic: ________________________ By: ____________ Where: __________

b. Topic: ________________________ By: ____________ Where: __________

c. Topic: ________________________ By: ____________ Where: __________

d. Topic: ________________________ By: ____________ Where: __________

e. Topic: ________________________ By: ____________ Where: __________

f. Topic: ________________________ By: ____________ Where: __________

18. Does your staff development program include information about working with children with disabilities?
___Yes ___No

19. Participants (protégés) will have an opportunity to make application to have a mentor assigned to them to guide them through working with children with disabilities and/or special needs. Please provide us with the names of participants so that we can assist in this process:

a. Name:____________________ Title_________ b. Name:____________________ Title_________
c. Name:____________________ Title_________ d. Name:____________________ Title_________
e. Name:____________________ Title_________ f. Name:____________________ Title_________
g. Name:____________________ Title_________ h. Name:____________________ Title_________
i. Name:____________________ Title_________ j. Name:____________________ Title_________
k. Name:____________________ Title_________ l. Name:____________________ Title_________

20. Would you support our staff development sessions by attending them yourself? ___Yes ___No

21. Would you have at least four all-parent meetings at the conclusion of our first eight sessions? ___Yes ___No

22. Comments:____
____
____

Completion of this form does not imply any commitment on your part to participate in the "inclusion" sessions; nor does it imply that your center will be chosen to participate in the sessions.

THANK YOU

Please return by MAIL or FAX to:
Susan Gold, Ed.D.
University of Miami's School of Medicine
Department of Pediatrics' Mailman Center for Child Development
1601 N.W. 12th Avenue; Suite 4015; Miami, FL 33136
Telephone (305) 243-6624/FAX (305) 243-5978

Please complete the following grid regarding each of your teaching staff members.

Codes to be used in completing the grid

***Highest level of education**

a. some high school
b. high school graduate or GED
c. some college courses
d. CDA degree
e. two-year college degree
f. four-year college degree
g. some graduate school
h. graduate degree

****Highest level of training**

a. no training
b. in-service workshops at my center
c. workshops in the community
d. workshops at professional meetings
e. courses in high school
f. courses in vocational school
g. CDA training
h. courses in a community college
i. AA in ECE or child development
j. related courses in a four-year college
k. BA/BS in ECE, child development, etc.
l. graduate level courses in related field
m. graduate degree in related field

POSITION: TEACHER or AIDE	CLASSROOM (Infant, Toddler, or Preschool)	*LEVEL OF EDUCATION	**LEVEL OF TRAINING	CURRENT SALARY ($/hr)	LENGTH OF EMPLOYMENT

EZ-PIP Curriculum
Book 1

1 Introduction to the Philosophy of Inclusion
2 Early Brain Development
3 Screening Young Children in the Classroom Setting
4 The Child Who Seems Different: Meeting Special Needs
5 Developmentally Appropriate Practices and Adapting the Classroom
6 Behavior Management
7 Intellectual Development: What You Can Do To Help
8 Speech and Language Development
9 Health Care
10 Working Together: Communication and Teamwork
11 Professionalism and Advocacy
12

WilsonJones MultiDex

The Enterprise Zone-Preschool Inclusion Project

Introduction to the Philosophy of Inclusion

1

Introduction to The Philosophy of Inclusion

Major Concepts and Content

For the success of this training it is vital that participants clearly understand the concept of inclusion. In this session we will introduce and define inclusion. It is our hope that participants will come to embrace the philosophy of inclusion.

The Division of Early Childhood of the Council for Exceptional Children defines inclusion as: "A value that supports the right of all children, regardless of their diverse abilities, to participate actively in natural settings within their communities" (2000). It is the belief in the right of every individual to be fully accepted and integrated into his or her community. This implies including children with special needs in the community and regular educational setting while providing the necessary support. The child with special needs is the child who in some ways is outside the range of what is considered characteristic of a particular age group (D.A.C.C.P. and the University of Miami). The special needs of children may range from difficulties in emotional, mental, social or physical development. The natural settings of children include the home and family, any educational setting and/or programs such as; child care, preschool, public or private school, play groups, etc. Collaboration, teamwork, flexibility, a willingness to take risks, and support from a whole array of individuals, services and institutions are necessary to successfully implement inclusion.

Materials

- ✓ Overhead projector/ flipchart/ or white board
- ✓ VCR and monitor
- ✓ What Do You Think?/ Paradigm Paralysis Test (Handout)
- ✓ IDEA and ADA (Transparencies)
- ✓ IDEA and ADA (Handouts)
- ✓ Video - ABC's of Inclusion
- ✓ Inclusion Guide (Handout)
- ✓ Inclusion is…Inclusion is not …(Handout)
- ✓ Benefits of Inclusion (Handout)
- ✓ Blank transparencies
- ✓ Evaluations

Teaching Strategies

I. **Icebreaker** (15 minutes) **Group Sharing** – The presenter asks participants to find a partner and introduce each other. Participants are asked to include in their introductions their names, place of work and occupation, why they are attending the training, past experiences in working with children with special needs and to come up with what they think are their strengths (abilities) and weaknesses (disabilities). Afterwards, each participant is asked to give a detailed introduction of their partner including the strengths and weaknesses. The presenter should highlight the diversity of abilities and how each individual is unique and special.

II. **Activity** (15 minutes) **"Paradigm Paralysis"** – The presenter distributes the "What Do You Think?" handout and allows sufficient time for participants to complete the test. Check the answers to the test as a group and initiate a discussion that centers around personal assumptions derived from previous experiences. The presenter should point out how sometimes we assume things are the same for everyone when in reality this may not be true. This is especially true for children with special needs. To successfully work with children with special needs we will need to be sensitive to the individual needs of each child. Consequently, care providers may need to make changes to their customary routines and problem solving strategies. Emphasize that change can be a very difficult and stressful process, however it can also be positive and productive.

III. **Large Group Discussion** (20 minutes) – The facilitator presents a review of the American history of children with special needs. This review should cover the conditions of children with special needs in the last centuries and decades. Emphasize segregation and the negative consequences this had on children with special needs. Discuss how this has changed and the current situation for children with special needs. Proceed with an introduction and discussion of the Individuals with Disabilities Education Act (IDEA), law 99-457 and the Americans with Disabilities Act (ADA). Distribute the brochures and handouts and review the information.

IV. **Video** (20 Minutes) Show the video ABC's of Inclusion (14 minutes). After viewing the video lead a group discussion. Ask participants what they liked and did not like, if they think the expectations are realistic and if they believe it would be possible to implement this type of program in their schools. Have participants identify possible barriers and problems and come up with ways to resolve these. Tell participants that throughout the training many of their concern with respect to inclusion of children with special needs will be addressed.

V. **Large Group Discussion** (30 minutes) Defining Inclusion – The facilitator distributes the handouts; "Inclusion Guide", "Inclusion is…Inclusion is not…" and the "Benefits of Inclusion". The presenter begins by defining the concept of inclusion and then clarifies what it is and what it is not. This may be done by reviewing the content in the handouts. The presenter should be attentive to any questions or opinions that participants may have. Answering questions and/or listening to opinions are sometimes good opportunities to clarify misconceptions. Next, have the following titles written or write them on overheads, a white board, flip chart, or chalk board, etc.:

- Benefits to children with special needs
- Benefits to children without special needs
- Benefits to parents of children with special needs
- Benefits to parents of children without special needs
- Benefits to early child care staff
- Benefits to early child care programs
- Benefits to society

Ask participants to think of the benefits and write them down under each title as they are given. Stress to participants that inclusion cannot work without the necessary administrative support, appropriate resources and adequate ongoing training.

VI. **Conclusion and Evaluation** (10 minutes) – The facilitator can review major points and ask if there are any questions. When there are no more questions, hand out the evaluations. While participants are filling out the evaluation write the date, time, location and topic of the next training session where everyone can see it. Read out the information and collect the evaluation.

References

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POSITION ON INCLUSION
DIVISION FOR EARLY CHILDHOOD
OF THE COUNCIL FOR EXCEPTIONAL CHILDREN

Adopted April 1993
Revised December 1993
Reaffirmed 1996
Updated 2000

Inclusion, as a value, supports the right of all children, regardless of abilities, to participate actively in natural settings within their communities. Natural settings are those in which the child would spend time had he or she not had a disability. These settings include, but are not limited to home, preschool, nursery schools, Head Start programs, kindergartens, neighborhood school classrooms, child care, places of worship, recreational (such as community playgrounds and community events) and other settings that all children and families enjoy.

DEC supports and advocates that young children and their families have full and successful access to health, social, educational, and other support services that promote full participation in family and community life. DEC values the cultural, economic, and educational diversity of families and supports a family-guided process for identifying a program of service.

As young children participate in group settings (such as preschool, play groups, child care, kindergarten) their active participation should be guided by developmentally and individually appropriate curriculum. Access to and participation in the age appropriate general curriculum becomes central to the identification and provision of specialized support services.

To implement inclusive practices DEC supports: (a) the continued development, implementation, evaluation, and dissemination of full inclusion supports, services, and systems that are of high quality for all children; (b) the development of preservice and inservice training programs that prepare families, service providers, and administrators to develop and work within inclusive settings; (c) collaboration among key stakeholders to implement flexible fiscal and administrative procedures in support of inclusion; (d) research that contributes to our knowledge of recommended practice; and (e) the restructuring and unification of social, educational, health, and intervention supports and services to make them more responsive to the needs of all children and families. Ultimately, the implementation of inclusive practice must lead to optimal developmental benefit for each individual child and family.

Endorsed by NAEYC – April 1994, April 1998

Permission to copy not required - distribution encouraged

WHAT DO YOU THINK?

THIS "TEST" WILL NOT BE TURNED IN OR GRADED, BUT IT CAN BE A FUN WAY TO CHECK YOUR SUSCEPTIBILITY TO "PARADIGM PARALYSIS".

1. HOW MANY FOUR CENTS STAMPS IN A DOZEN?

_____

2 HOW MANY BIRTHDAYS DOES THE AVERAGE PERSON HAVE?

_____

3. SOME MONTHS HAVE 30 DAYS, SOME HAVE 31. HOW MANY MONTHS HAVE 28 DAYS?

_____

4. I HAVE IN MY HAND 2 U.S. COINS WHICH TOTAL 55 CENTS IN VALUE. ONE IS NOT A NICKEL. WHAT ARE THE TWO COINS?

_____

5. IF YOU HAD ONLY ONE MATCH, AND ENTERED A ROOM WITH A KEROSENE LAMP, AN OIL HEATER, AND A CANDLE, WHICH WOULD YOU LIGHT FIRST?

_____

PUBLIC LAWS

- » P.L. 94-142 (3-5)
  - – Education for All Handicapped Children Act, 1975
  - – Free Appropriate Education all children (FAPE)
  - – Least Restrictive Environment (LRE)
- » P. L. 99-457 (0-2.11)
  - – Individuals with Disabilities Education Act, 1986 and 1990, Reauthorized
  - – Family Centered Support
- » P.L. 101-336
  - – American with Disabilities Act, 1990
  - – EASY access to facilities serving the public

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INCLUSION GUIDE

WHAT IS INCLUSION?

Inclusion refers to the placement of a child with special needs in the community and regular educational setting, with necessary aids, equipment, and support services.

WHO IS THE CHILD WITH SPECIAL NEEDS?

A child may be defined as having special needs if he or she is in some way outside the range of what is considered characteristic of a particular age group. The special need may vary from problems with emotional, mental, social, or physical development. Since every child is unique, these disabilities will differ in both form and degree of severity. Above all, it is important to remember that a child with special needs is more like than unlike any other normally developing child.

WHAT ARE SOME COMMON FEELINGS TO EXPECT WHEN WORKING WITH CHILDREN WITH SPECIAL NEEDS?

1. A frequent initial response may be avoidance. This response is an easy one because it allows one to escape from dealing with something uncomfortable. The avoidance occurs as a result of not knowing how to respond.
2. Another common response is one of sadness because we tend to think of the individual in terms of their lost potential.
3. Along with sadness may come a feeling of vulnerability because contact with children with special needs tends to make others more aware of "what can happen".
4. If the child does not catch up, in spite of all of the effort, several other feelings may arise. These may include resentment of the child, guilt, and sometimes even anger.

Keep in mind that these feelings are normal for persons who work with children with special needs. It is important to accept them but not let them dominate your attitude and efforts.

This reference guide is produced by the Dade Association of Child Care Programs (D.A.C.C.P.) and is a collaborative effort between the D.A.C.C.P. and the University of Miami, Mailman Center for Child Development. It is funded through a State of Florida Early Childhood Development Grant.

WHAT DOES IT TAKE TO SUCCESSFULLY INTEGRATE CHILDREN WITH SPECIAL NEEDS INTO REGULAR EARLY CHILDHOOD PROGRAMS?

When the process of integration begins, there are several things for the care giver to keep in mind. First of all, it is important that the child with special needs, like all children, experience success. A care giver may need to plan more carefully to ensure that the child with special needs succeeds in the learning activities provided. Secondly, a care giver must understand childhood development not necessarily in terms of age but in terms of a step by step process. For example, if a child is making sounds, it is likely that the next step will be words. Knowing child development will also help to identify which behaviors are age appropriate and which ones may be related to the disability. Finally, it is important that independence be encouraged by the care giver. A common tendency is to help too much; however, overprotection can be detrimental to the child's growth.

WHAT ARE SOME TECHNIQUES THAT CAN BE USED TO ENCOURAGE ACCEPTANCE AND UNDERSTANDING BY CHILDREN WITH TYPICAL NEEDS?

The attitude of the care giver is most important because children tend to model the behaviors of adults who are important in their lives. A care giver has the responsibility of giving children factual information in response to their questions about their classmates with special needs. At times it may be appropriate to begin a discussion concerning children with special needs in order to avoid misconceptions about the topic. This technique may be especially important if children begin to ridicule or tease a child with special needs. Another excellent technique that should be used daily is to plan integrated social experiences. This is particularly important since children tend to learn from each other.

HOW DOES ONE DEAL WITH THE PARENTS OF CHILDREN WITH SPECIAL NEEDS?

Since parents are the most important influence in a child's life, it is important for the care giver to help parents set realistic expectations for their children by sharing information about their child's progress and growth. Parents should be encouraged about their child's successes whenever possible. In addition, referrals to resources within the community should be presented.

HOW DOES ONE DEAL WITH THE PARENTS OF CHILDREN WITH TYPICAL NEEDS?

The parents of children with typical needs often need reassurance that the inclusion of children with special needs will not interfere with their child's care and progress. This is why it is important for the staff to respond to the needs of every child in the program. The enrollment of children with special needs should be handled in a routine manner in order to avoid unnecessary concern on the part of parents.

TIPS FOR WORKING WITH CHILDREN WITH SPECIAL NEEDS

- Encourage all children in the day care setting to work together.
- Accept different performance levels while encouraging each child to perform the skill correctly.
- Accept approximate performance while encouraging child to perform the skill correctly.
- Be a model of patience and acceptance to the children.
- Encourage patience and acceptance on the part of all children.
- Maintain a positive attitude toward ALL children.
- Maintain a sense of humor!
- Apply rules fairly to all children in a program.
- Select toys that are multisensory and encourage children to work together.
- Allow children with special needs (ie. visual impairment) to explore objects with their tongue and mouth for information gathering purposes.
- Never do for the child what that child can accomplish.
- Realize that it may take longer for a child to do a task without your help, but this is a valuable experience.

Suggestions for Infants

A loving, caring, and accepting environment is the best way to help an infant to later establish positive interactions with others. Resist the need to label infants into a special category of disability. At this age, diagnosis is difficult and the extent to which the disability will affect the infant is not known.

Infants need to be positioned with care.

Use colorful mobiles in cribs to stimulate interest and the use of eyes for tracking.

Choose bright, colorful toys that incorporate sound and texture into their structure.

Speak to infants, even though you don't know how much they will understand.

Establish vocal play and attempt to get the infant to imitate your sounds.

Smile and use eye contact with the infant.

Suggestions for Toddlers and Twos

Check the day care environment for safety. Children need to avoid obstacles while moving about their play area. Children with physical impairments may need more time to move from one place to another.

Do not allow children with special needs to become the favorites of the caretakers.

Do not let children with special needs be ignored.

Suggestions for Threes and Fours

Children with crutches, walkers, and other adaptive aids should be encouraged to move about the center freely. They must not be carried unnecessarily or they will never learn to move independently.

Children must be encouraged to accept differences in appearance as well as in ability.

Become familiar with the way a child learns. Notice how many times it takes to do the task. This will assist the care giver in setting realistic expectations.

Help the child build and maintain more than one relationship with an adult and a child. Do not let the child become dependent on one care giver.

Suggestions for Fives

Encourage children to do things for themselves. Some children will use aids such as magnifiers, walkers, hearing aids, prosthetic arms or legs. Remember that it might take longer for them to accomplish a task. Normally developing peers need to realize that using a different approach to a task is acceptable.

Children at this age must learn that different is okay, and that there are varying levels of performance in everyone, not just in people with disabilities. Often children with special needs feel that other children without disabilities are superior to them. They need to learn that everyone has strengths and weaknesses.

When grouping children, be sure that the disabled youngsters are mixed in with non-disabled peers. This will encourage socialization and promote learning from each other.

INCLUSION IS...

A PHILOSOPHY. It is a belief in every person's inherent right to participate fully in society. Inclusion implies acceptance of differences. It means making room for a person who would otherwise be excluded. Translating this philosophy into reality is a process collaboration, teamwork, flexibility, a willingness to take risks, and support from a whole array of individuals, services, and institutions.

A PRACTICE. It is the educational process by which all students, even those with disabilities, are educated together, with sufficient support, in age-appropriate, regular education programs in their neighborhood schools. The goal of inclusive education is to prepare all students for productive lives as full, participating members of their communities.

EVOLVING. As people learn more about inclusion, they understand that "full inclusion" means that students with Down syndrome are part of the regular education system--even if their curricular goals and needs differ from those of their classmates.

REWARDING FOR ALL PEOPLE INVOLVED. When inclusion is carried out appropriately, research has demonstrated benefits to students with Down syndrome as well as to their peers. Friendships develop, students without disabilities learn to appreciate differences, and students with disabilities are more motivated. All of this carried home and into the community.

INCLUSION IS NOT...

A PASSING FAD. Numerous federal district court decisions have affirmed the right of students with Down syndrome to attend regular classes full time when the educational benefits for the students warrant such a placement. Inclusion, with its focus on outcomes, is the spirit of the Individuals with Disabilities Education Act (IDEA) and the trend for the future.

DUMPING. It does not mean that a child with special needs is placed in a classroom without adequate support and appropriate services. It does not mean that undue burdens are placed on teachers and peers. Thoughtful planning, continual monitoring, and sufficient support are all part of successful inclusion programs.

EASY. Parents education, peers and administrators are all partners in the inclusion process and must work together to make it successful. On-going problem solving is involved.

MAINSTREAMING. Inclusion is more than mainstreaming. Mainstreaming implies that a child from a special education class visits the regular class for specific, usually non-academic, subjects. Inclusion means that a student with special needs is a part of the regular class, even if he or she received occasional services in another setting.

Benefits of Inclusion

Much work has been done in the area of including children with special needs into early education and care programs. Much work still needs to be done. One important piece of this work is helping people who may be skeptical or afraid of inclusion understand the many benefits of inclusion. The chart that follows provides descriptions of the benefits of inclusion as experienced by the staff, parents, policy makers, and most importantly the children who participated in the programs evaluated for this manual.

Children With Special Needs	◆ Children have opportunities to experience and model age-appropriate, develop mentally appropriate behavior ◆ Children are motivated to develop appropriate knowledge, skills, and attitudes by the developmentally appropriate environment ◆ Children demonstrate improvement in social skills, interpersonal relationships, acceptance of differences, and independence ◆ Children demonstrate improved self-esteem
Children Without Special Needs	◆ Children learn that everyone is not the same and that they do not have to be afraid of some one who is different from them ◆ Children learn patience and empathy for other children who are significantly different from themselves ◆ Children gain firsthand experiences with the use and care of adaptive equipment required by children with disabilities
Parents of Children With Special Needs	◆ Parents have an opportunity to choose an inclusive program for their child. Often this choice may allow the young child with special needs to receive appropriate care near his/her home and at the same location as his/her sibling or other children living with the same caregiver ◆ Parents develop an appreciation of similarities in the parenting experience regardless of whether their child has a disability or not
Parents of Children Without Special Needs	◆ Parents develop an appreciation of similarities in the parenting experience regardless of whether their child has a disability or not

- Parents become aware of access and integration issues

Early Education and Care Staff

- Staff develop an appreciation of the uniqueness of each child, both those with and without special needs, and a desire to address each child's needs
- Staff receive information and participate in experiences that abate their fears about providing care and instruction for young children with special needs
- Staff increase their expectations for the development of the young child with special needs
- Staff express intrinsic reward of seeing young children with special needs make progress
- Staff become aware of access and integration issues

Early Education and Care Programs

- Child care centers receive recognition by members of the community and/or representatives of community organizations for the efforts made to improve the quality of care and include children with special needs. Newspaper articles, newsletter articles, and certificates of appreciation describe the positive work of the program staff.
- Child care centers may receive in-kind and financial support from members of the community or community organizations to assist them in their efforts to improve the quality of care and the inclusion of children with special needs
- Child care centers are able to market the program as providing services to young children with special needs and acquire a new clientele.

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The Enterprise Zone-Preschool Inclusion Project

Early Brain Development

2

Early Brain Development

Major Concepts and Content

Recent research has demonstrated the phenomenal growth and development that occurs in children's brains during the first three years of life. It is estimated that there are 100 billion brain cells in the human brain at birth and these cells form connections at an incredible rate, leading to approximately 1000 trillion connections by age 3. While these numbers may seem incomprehensible, what they are indicating is that very early childhood is a crucial time for brain growth and teachers and parents play an important role in fostering healthy development.

Babies need certain key experiences to optimize brain development. Emotional and physical bonding are critical first steps. Attention to health and safety is paramount to ensuring babies' opportunity to develop fully. Exposure to language through talking, singing and reading assist babies' language acquisition. Opportunities for movement in combination with healthy nutrition will maximize physical development. Babies develop social skills through interaction with others and need guidance from their caregivers regarding appropriate behavior. Finally, early identification of delays or disabilities is necessary to ensure interventions that can help young children reach their full potential.

In addition to the factors that positively affect brain development, parents and teachers should be aware of the factors that can negatively impact babies' brains. These include exposure to toxins such as pre-natal exposure to alcohol, tobacco and other drugs or post-natal exposure to environmental toxins such as lead or cleaning chemicals. Brain damage can also be caused by injuries such as near drowning, auto accidents and shaking. The impact of stress in response to abuse and neglect can cause long-term brain damage. Early stimulation is necessary for healthy brain development, without it the brain begins to lose it's ability to grow and learn.

Materials

- ✓ Brains- Fact Sheet (Handout and transparencies)
- ✓ Overhead projector
- ✓ Video – The First Years Last Forever
- ✓ VCR and monitor
- ✓ Large white construction paper – 1 sheet per participant
- ✓ Color Markers – 1 box per 3 participants
- ✓ Hands On Brain (Handout) – Nancy Margulies[1]
- ✓ Flip Chart and Easel

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[1] See reference section for information on where to obtain a copy of the handout.

- ✓ How to Build A Baby's Brain (Handout) – Newsweek article
- ✓ Evaluations

Teaching Strategies

I. **Icebreaker** (10 minutes) **Name Game** - Participants will play the "Name Game" in which they are asked to introduce themselves to a person sitting next to them. Once they have found a partner they will explain to the partner how they got their name. For instance, were they named after a parent or other relative or is their name the same as a celebrity? When each person has introduced himself or herself to their partner, they will introduce their partner to the group. The group leader should point out any reoccurring themes such as family names, the role of fathers in choosing names, tradition and current events at the time of birth. This activity will assist participants in getting to know one another on a personal basis, as they will probably be continuing the training sessions together. Introducing each other to the group will help them remember at least one other person's name. The group leader should share her personal "name story" and then introduce the next activity.

II. **Large Group Activity** (30 minutes) **Mind Mapping** - The group leader distributes large paper and markers and asks participants to write the following question in the center of the paper; " What do babies' brains need to grow?" The group leader asks participants to think of words, phrases or pictures that would answer this question and to use their color markers to write or draw the words and pictures around the central question. This technique encourages right brain thinking and relieves the pressure of composing thoughts in a linear way. (See attached sample and the book Mapping Inner Space by Nancy Margulies, M.A.,1991 for more information). When participants are finished with their individual work the group leader writes the same question "What do babies' brains need to grow?" in the center of the flip chart paper and asks participants to share some of their ideas. The group leader then writes the words and draws the pictures on the flip chart. Themes may include love, attention and touch, food, safe shelter, interaction and touch, talking, reading and music, physical activity and play. Depending on the audience different themes may emerge. For instance, among early childhood educators they may focus on learning areas that they have set up in their classrooms. Parents may focus more on health and safety issues or things they have heard about in the media. If the presenter is uncomfortable with drawing simple pictures, it is acceptable to simply use words. However try to at least use different colors of markers as seeing colors as opposed to the usual black marker/white paper format stimulates the brain.

III. **Video and Discussion** (20 minutes) - Show approximately 10 minutes of the First Years Last Forever. The first segment focuses on what infants need to develop. Ask participants to notice if any of the themes that they generated in the previous activity come up in the video and discuss these themes as they relate to the participants.

IV. **Break** (10 minutes) - You may wish to play music, provide food and beverages and invite participants to browse through any materials that you brought that are related to the session.

V. **Large Group Discussion** (20 minutes) - Introduce this discussion by asking participants to raise their hand if they can explain how electricity works. Assume that not everyone will raise their hands! Then ask them to raise their hand if they know how to turn on the lights in their home. Assume that all hands will be raised. Use this as an analogy to brain anatomy. Let them know that they do not need to memorize the parts of the brain or the number of cells to understand how to "turn on the lights" in their babies' brains. Distribute the handouts and use the overhead transparencies to discuss the major points of brain development. Comparing the structure of the brain cell (neuron) to a tree branch helps some people conceptualize what it looks like. Also point out that the connections (synapses) are formed as a direct result of the baby's experience. Discuss the concept of pruning in which the brain strengthens some connections and lets others die off. This can be compared to the process that occurs when seeds are planted and some thrive while others weaken and die. Remind participants that this is a healthy process and does not indicate that a three year old with 1000 trillion connections is more intelligent than a twenty year old with 500 trillion connections. Next focus on the things that are vital to healthy brain development and remind them that they probably already came up with many of the same answers during the mind mapping activity. Finally point out the factors that can have a negative impact on brain development. Again, depending on your audience, you may want to focus on proper pre-natal care and avoidance of toxins such as drugs with parents, or on the importance of early stimulation with caregivers of infants.

VI. **Hands On Brain** (20 minutes) - Tell participants that they are now going to learn a way to remember some of the parts of the brain and what the parts control. Ask them if they know any finger plays that help children with counting or other concepts (expect examples such as "Five little monkeys jumping on the bed" or "This little piggy went to market"). Tell them that children and adults can often remember more information if they use their body in some way to associate with the idea. (This is the concept of kinesthetic learning in multiple intelligence theory). Ask them to make both hands into a fist with the thumbs facing them and the fingernails of each hand touching each other, (see attached photo). Tell them that a baby's brain is a little larger than the size of their hands at birth. The left hand represents the left hemisphere and the right hand represents the right hemisphere. The fingernails represent the corpus collusum, which allows the two hemispheres to communicate. The palms of both hands represent the limbic system, which controls the emotions and the hormones. The wrists represent the brain stem or reptilian portion of the brain, which controls automatic functions such as the heartbeat, breathing and blood pressure. The area of the brain that corresponds to vision (the occipital lobe) is represented by the little fingers and they are tucked deep in the back of the brain.

VII. **Conclusion and Evaluation** (10 minutes) - Group leader can review major points and ask if there are any questions. When questions are finished hand out the evaluations. While participants are filling out the evaluation the group leader should write the date, time, location and topic of the next training session on the flip chart. Read the information aloud and collect the evaluation. (Having the information presented in two separate modalities increases the likelihood that participants will return!) Have copies of Newsweek article (How to Build a Babies' Brain) available to participants to take with them in case they want more information.

Activities to try at home or at the child care center:

- ✓ Have two people talk to a newborn infant at the same time and see which one she turns her head toward.
- ✓ Put two or three large simple patterns in front of an infant and see which one he prefers by looking at it longer. Experiment with different colors, such as

high contrast black and white or pastels and with different shapes such as circles, simple faces, and checkerboards.

✓ Play different types of music for older infants and observe their response to it. Do they prefer fast or slow, lullabies or Barney?

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Margulies, N. (1991). *Mapping Inner Space*. Tucson, AZ: Zephyr Press.

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Multiple Intelligences:

✓ Bodily/Kinesthetic
✓ Visual/Spatial
✓ Verbal Linguistic
✓ Interpersonal
✓ Musical/Rhythmical
✓ Intrapersonal
✓ Logical/Mathematical

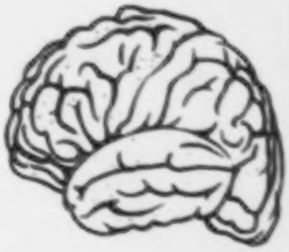
For more information on Howard Gardner's Multiple Intelligence theory contact www.newhorizons.org/trm_gardner.html

Brain Facts

A baby is born with over 100 billion brain cells, all that he will need for the rest of his life.

By age three children's brains have formed twice as many connections as they will ever need (roughly 1,000 trillion connections).

At age 20 the brain has pruned the connections down to 500 trillion synapses.



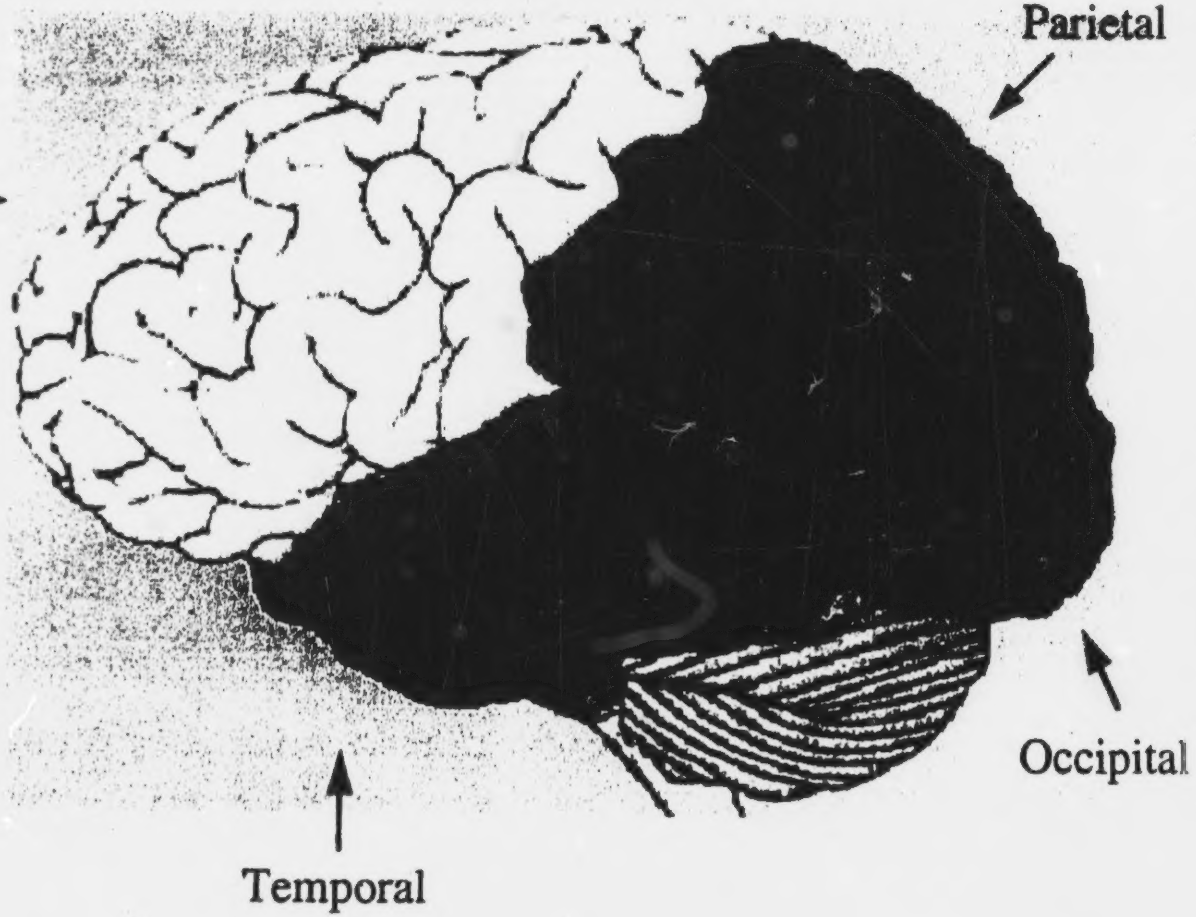
If a baby's brain is not stimulated it will begin to lose the ability to learn and grow.

Talking, singing, and reading to your baby help stimulate brain development.

Feeling safe, secure and nurtured helps your baby's brain to grow.

Abuse and neglect can cause a baby's brain to develop differently. These effects become "hardwired" into the brain and cannot be reversed later in life. The window of opportunity becomes closed forever.

Geography of our cerebral cortex


Frontal
Parietal
Occipital
Temporal

Right & Left
hemispheres
collaborate
to produce a
unified
mental experience

Center for Educational Enhancement and Development

The Enterprise Zone-Preschool Inclusion Project

Screening Young Children

3

Screening Young Children in the Classroom Setting

Major Concepts and Content

One of the best ways to obtain information about a child's strengths and potential deficits is by administering a screening instrument. Screenings are quick, low-cost methods for classroom teachers to determine whether students may need to be referred to a professional for more in-depth evaluations for possible health, sensory, or developmental differences. Children can be screened to determine developmental delays using the Developmental Observation Checklist System (DOCS). This session is an introduction to screenings in general, and specifically an introduction to administering the DOCS.

Materials

- ✓ Screening Definition (Transparency)
- ✓ Evaluation Definition (Transparency)
- ✓ Six areas of Child Development (Transparency)

- ✓ Basic Assessment Protocol (Transparency)
- ✓ DOCS protocol, Part I: pages 1 & 2 (Transparencies)
- ✓ DOCS protocol, Part II: pages 1 & 2 (Transparencies)
- ✓ DOCS, Part I protocols (2 per teacher)
- ✓ DOCS, Part II protocols (2 per teacher)
- ✓ Flip chart or chalkboard
- ✓ Markers or chalk
- ✓ Evaluations

Teaching Strategies

I. **Introduction** (10 minutes). - Begin the session by stressing the importance of the teacher's role in early identification of children with special needs. Extrapolate this idea to include the concept of early identification as the first step of prompt remediation of special needs.

II. **Definitions: Screenings vs. Evaluations Concepts** (5 minutes) - Discuss with the group the concepts of screening and evaluation. Use the screening and evaluation transparencies to define, compare, and contrast these concepts. Be certain that teachers or care providers understand that they are generally directly involved in screenings, while specialists generally do evaluations. Explain to the participants that screening refers to a quick test, which generally takes between 10 and 30 minutes. It helps determine if a child might have special needs. Some screening tests can be administered by teachers and require a minimum amount of training. Professionals such as nurses, psychologists, speech/language pathologists, and ophthalmologists conduct other types of screening tests.

Screening tests can be administered to an individual or to a group. These tests report what tasks the child is able to do at the time of the screening and are not predictors of future ability. It is crucial to consider cultural, social, and environmental factors when doing any type of assessment. If a child does not perform the selected tasks that children of the same age normally are able to do, the examiner is alerted to the fact that the child may have a problem and may need further evaluation.

On the other hand an evaluation refers to more in-depth testing of children that looks at five or six developmental areas and generally takes several hours. A psychologist or doctor usually administers these types of evaluations.

III. **Six Areas of Child Development** (15 minutes) Group activity. - Use the transparencies to explain the six areas of child development.

- ***Cognitive*** -acquisition of thoughts and knowledge
- ***Fine motor*** -using the small muscles of the hands and fingers
- ***Gross motor*** -using the larger muscles of the body
- ***Language*** -using and organized linguistic system to communicate

- ***Self-help*** -performing daily self-care tasks such as grooming, toileting, dressing
- ***Social-emotional*** - developing a sense of self and relationship to others

Be certain to show how each of these areas of development are interrelated and dependent upon the other areas. Give an example of how slow development in one area could delay development in other areas. Ask for other examples of how these areas are interrelated and how delayed development in one area could affect other areas.

IV. **Preschool domains targeted for screening** (10 minutes). Briefly discuss the areas that are screened during the preschool years. These are: health, vision, hearing, speech and language, cognitive, gross motor, fine motor, social-emotional development and self-help skills.

V. **Break** (10 minutes)

VI. **Introduction to the DOCS** (5 minutes) - Explain to participants that the DOCS is a screening tool used to assess cognitive, gross motor, fine motor, social-emotional, and self-help skills. It helps identify students who are not developing at the expected rate.

VII. **Establishing test age** (20 minutes) **Activity** - Use the transparencies, the chalkboard or the flip chart to show participants how to subtract the child's date of birth from the test date in order to get an exact chronological age. Focus on how to borrow from the various columns (days, months, years) correctly. Include information about rounding up the month if there are 15 or more days in the child's age at test date.

Provide several opportunities for the participants to establish a test age for a hypothetical child using a birth date and test date that you provide. It may be helpful to have the teachers figure out a hypothetical chronological age as a group first, and then give them several opportunities to figure out additional ages on their own.

VIII. **Determining a basal and ceiling** (10 minutes) Use the DOCS transparencies to show participants how to use the chronological age to determine a beginning point for the test, a basal, and an ending point, a ceiling.

IX. **Practice using the DOCS** (15 minutes) - Have participants practice administering a complete DOCS to a single hypothetical child. Lead them through the process of determining a chronological age, determining a basal, answering questions about the hypothetical child's abilities (you may tell them what the child is capable of doing), and determining a ceiling.

X. **Introduction to DOCS, Part II protocol** (10 minutes). Use the DOCS transparencies to introduce the DOCS, Part II. Note that the first page of the DOCS Parts I and II require the same information, so there is nothing new to learn on the first page. For the second page of the DOCS, Part II, instruct the teachers how they should use the Likert-like scale to rate each of the items on that page.

XI. **Homework Assignment** (5-20 minutes). Ask for and answer any questions regarding the material covered in the session. If necessary, do a second full example of how to fill out the complete DOCS protocols (Parts I and II) for a hypothetical child. When you are confident that the participants understand the concepts involved in administering a DOCS protocol, assign them a practice assessment using the DOCS protocols (Parts I and II). Advise them to do the practice assessment on a child who is NOT in their classroom. Suggest that they assess a child with whom they have contact with outside of the school setting (a member of their extended family, a well-know neighbor's child, etc.). Request that the assignment be done for the next meeting.

XII. **Conclusion and Evaluation** (10 minutes) - Ask participants to fill out and hand in evaluations. Write the date, time, location and topic of next session and read it out loud to participants before they leave.

References

Hresko, W.P., Miguel, S. A. , Sherbenou, R. J., & Burton, S. D. (1990) *Developmental Observation Checklist System*. Austin, TX: Pro-Ed Inc.

Kelley, J. C. (1990). Intellectual Development: What you can do to help. "In C. F. Abbott & D. M. Fernandez (Eds.), *Mitch Module 1, Model of Interdisciplinary Training for Children with Handicaps: A Series for Caregivers of Infants and Toddlers*. Florida Department of Education. Division of Public Schools. Bureau of Education for Exceptional Students.

SCREENING

a BRIEF inexpensive assessment procedure designed to identify children who should receive more in-depth evaluation.

EVALUATION

***COMPREHENSIVE** procedure(s) used by appropriate qualified personnel to determine a child's initial eligibility for services. It is an examination used to determine the nature of the child's problems, and to suggest the cause of the problems and possible remediation.*

Six Areas of Child Development

cognitive—acquisition of thought and knowledge
fine motor—skills using the small muscles of the hands and fingers
gross motor—skills using the larger muscles of the body
language—an organized system of linguistic symbols (usually words) to communicate
self-help—performing daily care tasks such as dressing, grooming, toileting
social-emotional—sense of self and relationship to others

These areas all work together as a child learns and exhibits new skills. for example, a baby may notice the caregiver holding a ball (cognitive), crawl toward the caregiver and reach for the ball (gross motor), use five fingers to grasp the ball (fine motor), say "ball" (language) and feel proud and happy (social-emotional).

FOUR-YEAR-OLD-CHILD DATA SHEET for the
BRIGANCE® PRESCHOOL SCREEN FOR THREE- AND FOUR-YEAR-OLD CHILDREN

4Y

A. CHILD DATA

Child's Name ____________ Date of Screening (Year ____ Month ____ Day ____) School/Program ____________

Parents/Guardian ____________ Birthdate ____ ____ ____ Teacher ____________

Address ____________ Age ____ ____ ____ Assessor ____________

B. SCREENING ASSESSMENTS / **C. SCORING**

Page	Assessment Number	Skill (*Circle the skill for each correct response. Make notes as appropriate.*)	Number of Correct Responses	Point Value	Child's Score
14	1B	**Personal Data Response:** Orally gives 1. first name 2. last name 3. middle name 4. age	×	1 point each	/4
15	2B	**Identifies Body Parts:** Points to or touches 1. thumbs 2. toes 3. neck 4. stomach 5. chest 6. back 7. knees 8. chin 9. fingernails	×	1 point each	/9
16	3B	**Gross Motor Skills:** 1. Stands on one foot one second. 2. Walks tiptoe four steps. 3. Walks forward heel-and-toe four steps.	×	3 points each	/9
17	4	**Tells Use of Objects:** Tells use of 1. stove 2. coat 3. car	×	3 points each	/9
18	5B	**Repeats Sentences:** Repeats sentences of 1. four syllables 2. six syllables 3. eight syllables	×	3 points each	/9
19	6B	**Visual Motor Skills:** Copies 1. — 2. | 3. +	×	3 points each	/9
20	7B	**Number Concepts:** Demonstrates by giving 1. two 2. three 3. five	×	3 points each	/9
21	8B	**Builds Tower with Blocks:** Builds a tower with 1. 6 blocks 2. 7 blocks 3. 8 blocks 4. 9 blocks 5. 10 blocks	×	2 points each	/10
22	9	**Identifies Colors:** Points to 1. red 2. blue 3. green 4. yellow 5. orange	×	2 points each	/10
23	10B	**Picture Vocabulary:** Names 1. boat 2. kite 3. wagon 4. ladder 5. scissors 6. leaf	×	2 points each	/12
24	11	**Prepositions and Irregular Plural Nouns:** Uses 1. prepositions 2. irregular plural nouns	×	5 points each	/10
			Total Score =		/100

SAMPLE

D. OBSERVATIONS

1. Handedness: Right ____ Left ____ Uncertain ____
2. Pencil Grasp: Fingers ____ Fist ____
3. Speech: Understandable ____ Immature ____
4. Other: *(Record below or on the back of this form.)*

E. SUMMARY *(Complete only if child is screened with group.)*

Compared to other children screened in this group,

1. this child scored .... Lower ____ Average ____ Higher ____
2. this child's age is.............................. Younger ____ Average ____ Older ____
3. this child's teacher's rating is .... Lower ____ Average ____ Higher ____
4. this child's assessor's rating is .... Lower ____ Average ____ Higher ____

F. RECOMMENDATIONS

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FOUR-YEAR-OLD-CHILD DATA SHEET for the *BRIGANCE® PRESCHOOL SCREEN FOR THREE- AND FOUR-YEAR-OLD CHILDREN*

4Y

A. CHILD DATA

Child's Name ______________ Date of Screening (Year ____ Month ____ Day ____) School/Program ______________
Parents/Guardian ______________ Birthdate ____ ____ ____ Teacher ______________
Address ______________ Age ____ ____ ____ Assessor ______________

SAMPLE

B. SCREENING ASSESSMENTS / **C. SCORING**

Page	Assessment Number	Skill *(Circle the skill for each correct response. Make notes as appropriate.)*	Number of Correct Responses	Point Value	Child's Score
14	1B	**Personal Data Response:** Orally gives 1. first name 2. last name 3. middle name 4. age	×	1 point each	/4
15	2B	**Identifies Body Parts:** Points to or touches 1. thumbs 2. toes 3. neck 4. stomach 5. chest 6. back 7. knees 8. chin 9. fingernails	×	1 point each	/9
16	3B	**Gross Motor Skills:** 1. Stands on one foot one second. 2. Walks tiptoe four steps. 3. Walks forward heel-and-toe four steps.	×	3 points each	/9
17	4	**Tells Use of Objects:** Tells use of 1. stove 2. coat 3. car	×	3 points each	/9
18	5B	**Repeats Sentences:** Repeats sentences of 1. four syllables 2. six syllables 3. eight syllables	×	3 points each	/9
19	6B	**Visual Motor Skills:** Copies 1. — 2. | 3. +	×	3 points each	/9
20	7B	**Number Concepts:** Demonstrates by giving 1. two 2. three 3. five	×	3 points each	/9
21	8B	**Builds Tower with Blocks:** Builds a tower with 1. 6 blocks 2. 7 blocks 3. 8 blocks 4. 9 blocks 5. 10 blocks	×	2 points each	/10
22	9	**Identifies Colors:** Points to 1. red 2. blue 3. green 4. yellow 5. orange	×	2 points each	/10
23	10B	**Picture Vocabulary:** Names 1. boat 2. kite 3. wagon 4. ladder 5. scissors 6. leaf	×	2 points each	/12
24	11	**Prepositions and Irregular Plural Nouns:** Uses 1. prepositions 2. irregular plural nouns	×	5 points each	/10

Total Score = /100

D. OBSERVATIONS

1. Handedness: Right ____ Left ____ Uncertain ____
2. Pencil Grasp: Fingers ____ Fist ____
3. Speech: Understandable ____ Immature ____
4. Other: *(Record below or on the back of this form.)*

____
____
____

E. SUMMARY *(Complete only if child is screened with group.)*
Compared to other children screened in this group,

1. this child scored .... Lower ____ Average ____ Higher ____
2. this child's age is .... Younger ____ Average ____ Older ____
3. this child's teacher's rating is .... Lower ____ Average ____ Higher ____
4. this child's assessor's rating is .... Lower ____ Average ____ Higher ____

F. RECOMMENDATIONS

____
____

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A. CHILD DATA

Child's Name: Susan Otis
Parents/Guardian: Fred and Maria Otis
Address: 322 Flagstaff Drive
Date of Screening: 8 8 15
Birthdate: 81 2 10
Age: 4 6 5
School/Program: Hammond
Teacher: Ben Haywood
Assessor: Ruth Yakaus

B. SCREENING ASSESSMENTS / C. SCORING

Page	Assessment Number	Skill (Circle the skill for each correct response. Make notes as appropriate.)	Number of Correct Responses	Point Value	Child's Score
14	1B	**Personal Data Response:** Orally gives [✓ 1 first name] [✓ 2 last name] 3 middle name [✓ 4 age]	3 ×	1 point each	3 /4
15	2B	**Identifies Body Parts:** Points to or touches [✓ 1 thumbs] [✓ 2 toes] [✓ 3 neck] [✓ 4 stomach] [✓ 5 chest] 6 back 7 knees [✓ 8 chin] [✓ 9 fingernails]	7 ×	1 point each	7 /9
16	3B	**Gross Motor Skills:** [✓ 1 Stands on one foot one second.] [✓ 2 Walks tiptoe four steps.] [✓ 3 Walks forward heel-and-toe four steps]	3 ×	3 points each	9 /9
17	4	**Tells Use of Objects:** Tells use of [✓ 1 stove] 2. coat [✓ 3 car]	2 ×	3 points each	6 /9
18	5B	**Repeats Sentences:** Repeats sentences of [✓ 1 four syllables] [✓ 2 six syllables] 3. eight syllables	2 ×	3 points each	6 /9
19	6B	**Visual Motor Skills:** Copies [✓ 1 —] [✓ 2 |] 3. +	2 ×	3 points each	6 /9
20	7B	**Number Concepts:** Demonstrates by giving [✓ 1 two] [✓ 2 three] 3. five	2 ×	3 points each	6 /9
21	8B	**Builds Tower with Blocks:** Builds a tower with [✓ 1 6 blocks] [✓ 2 7 blocks] [✓ 3 8 blocks] [✓ 4 9 blocks] 5 10 blocks	4 ×	2 points each	8 /10
22	9	**Identifies Colors:** Points to [✓ 1 red] [✓ 2 blue] [✓ 3 green] [✓ 4 yellow] [✓ 5 orange]	5 ×	2 points each	10 /10
23	10B	**Picture Vocabulary:** Names [✓ 1 boat] [✓ 2 kite] [✓ 3 wagon] 4 ladder 5 scissors [✓ 6 leaf]	4 ×	2 points each	8 /12
24	11	**Prepositions and Irregular Plural Nouns:** Uses [✓ 1 prepositions] [✓ 2 irregular plural nouns]	2 ×	5 points each	10 /10
			Total Score =		79 /100

D. OBSERVATIONS

1. Handedness: Right ✓ Left ____ Uncertain ____
2. Pencil Grasp: Fingers ✓ Fist ____
3. Speech: Understandable ✓ Immature ____
4. Other: *(Record below or on the back of this form.)*

Performed better with praise and encouragement

E. SUMMARY *(Complete only if child is screened with group.)*

Compared to other children screened in this group.

1. this child scored .... Lower ____ Average ✓ Higher ____
2. this child's age is .... Younger ____ Average ____ Older ✓
3. this child's teacher's rating is .... Lower ✓ Average ____ Higher ____
4. this child's assessor's rating is .... Lower ____ Average ✓ Higher ____

F. RECOMMENDATIONS

No further assessment is necessary at this time

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University of Miami Mailman Center for Child Development

The Enterprise Zone-Preschool Inclusion Project

Session III: Screening Part 2: The Purposes of DOCS

The DOCS has the following seven purposes:

1. To identify both those infants and children who are developing normally and those significantly below their peers in acquiring cognitive, language, social, and motor abilities and who may be candidates for additional assessment or intervention.

2. To identify those infants and children whose adjustment behavior may indicate that they are at risk for developmental problems and are candidates for additional assessment.

3. To identify those family concerns such as stress and lack of support that may impact on the infant's or child's development.

4. To more accurately determine the specific professional to whom referral may be made and to aid in directing further diagnostic assessment.

5. To serve as a measurement device in research studies pertaining to early identification of, and intervention with, high-risk population.

6. To give direction to instructional practice.

7. To document educational progress.

The Enterprise Zone-Preschool Inclusion Project

The Child Who Seems Different: Meeting Special Needs

4

The Child Who Seems Different: Meeting Special Needs

Major Concepts and Content

Parents and teachers of young children are often unsure of the course of normal development and when should they be concern about their child's development. In this module, disabilities will be defined, the conditions that put a child at risk will be discussed, and the referral process and resources will be described.

Young children with disabilities have the right to be included with young children without disabilities. According to the Individuals with Disabilities Education Act (IDEA), young children, birth through age three, with disabilities should receive specialized services in the "natural environment", that is, the setting the child would normally attend if he or she did not have a disability. Children over the age of three must be served in the "least restrictive environment" (See handout). While these concepts sound easy in principle they are sometimes more challenging to carry out in practice.

It is important for early childhood educators to be knowledgeable about typical and atypical development. During this session, you will learn about specific disabilities and where to go for more information. You will also learn about the Americans with Disabilities Act (ADA) and its implications for child caregivers (See handout).

Early childhood teachers learn about development in several ways. The first is by informal observation of young children in childcare settings. Caregivers start to notice the natural progression of development in different areas and may be the first to realize when a child is having difficulty in one or more of these areas. Another way that caregivers learn about early development is through more formal methods, such as completing developmental checklists or screening tools. Subsidized childcare centers in Florida are now required to screen children in their care for potential delays and to refer children with suspected delays for further assessment. Some early childhood educators receive guidance in typical and atypical development during their initial training. Still, others actively seek out additional training at conferences or through college classes. Knowledge of typical and atypical development is critical for all early care and education providers.

Children with developmental delays or disabilities will have a better chance of succeeding if they receive intervention services when they are very young. When early intervention services are provided the developmental differences between typical and atypical children will become less significant as they grow older. However, many pediatricians, family members, and friends may tell a parent to simply wait and their child will "outgrow" the problem or "catch up later". While this advice may be accurate, it is better to err on the side of caution, than to wait until a problem becomes severe.

Types of Disabilities

Developmental Disabilities – are functionally defined in federal law to include a variety of disabilities that manifest before a child's eighteenth birthday. This term is usually used when a baby or young child does not acquire new abilities within the expected time range and displays behaviors inappropriate for his or her age. They include cerebral palsy, autism, epilepsy, mental retardation, and spina bifida.

Sensory Disabilities - Refer to visual and hearing impairments. Blindness refers to a condition with no vision or only light perception. Low vision refers to limited distance vision or the ability to only see items close to the eyes. In deafness, hearing loss is so severe that the sense of hearing is non-functional. There are many types of visual and hearing impairments.

Physical Disabilities – include orthopedic or health impairments. They describe medical or structural conditions that may disrupt a child's development. Many times when an early childhood caregiver is presented with the idea of providing care for a child with a disability, the assumption is that the child will be in a wheelchair. Most physical disabilities do not require such specialized equipment and in fact many physical therapists are using walkers, scooters, or braces instead of wheelchairs to encourage young children to move around. However, with training, caregivers can make classroom accommodations that will allow children to use any specialized equipment.

Other physical disabilities that early caregivers may encounter will be health impairments such as asthma, diabetes and cystic fibrosis. These children are easily included in typical childcare settings when caregivers are provide with proper training and support.

Speech/language Disabilities - One of the most common and under referred disabilities is a speech or language delay. Speech delays refer to the child's difficulty to produce audible sounds that serve as the basic tool for oral expression. They may be caused by many factors including ear infections, which lead to intermittent hearing loss and subsequent difficulty with articulation. Language problems refer to the child's difficulty in communicating. Language involves receptive and expressive language skills. Receptive language refers to the ability of the child to make sense of what is said. An example might be that a child cannot remember what he or she was told to do. Expressive language refers to the child's ability to make others understand what he is saying. An example might be a child who mixes up the order of words in a sentence.

Behavioral/Emotional Disabilities – Behavior and emotional problems in children are very difficult to define. Although not widely liked by professionals, but helpful in determining eligibility for special services, is the definition stated in the Individuals with Disabilities Education Act (IDEA). The key points of this definition include:

1. An inability to learn that cannot be explained by intellectual, sensory, or health factors;
2. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
3. Inappropriate types of behavior or feelings under normal circumstances;
4. A general pervasive mood of unhappiness or depression
5. A tendency to develop physical symptoms or fears associated with personal or school problems." [Code of Federal Regulations, Title 34, Section 300.7(b)(9)]

Perhaps some of the most challenging, are children with disabilities such as attention deficit hyperactivity disorder (ADHD) and more severe problems such as autism and pervasive developmental disorder (PDD). These disabilities negatively affect social skills, behavioral control, and communication. Caregivers need to learn specific strategies for helping these children get along in a group setting. These may include structuring the environment, behavior modification, learning how to use a specialized communication system, and giving ample opportunity for physical activity.

Specific Learning Disabilities – A disorder in one or more of the basic psychological processes involved in understanding or using language, spoken or written. It may manifest itself in an inability to learn, think, speak, read, write, spell or do mathematical calculations. They do not include problems that are the result of visual, hearing or motor impairments, mental retardation or environmental disadvantages.

Despite the challenges of including children with disabilities in typical child care settings, it is important to make parents, center directors, and caregivers aware of a very important fact. It is the law! Many people are not aware that the *1992* Americans with Disabilities Act (ADA) has provisions for all people with disabilities and this includes children. Just as all businesses, childcare centers are required by law to make all the necessary accommodations thus people with disabilities may have access to their facility. Businesses have focused on providing accessible parking spaces, bathrooms, wheelchair ramps, elevators, and signs in Braille. For the childcare community these accommodations involve having an inclusive policy for children and families with disabilities and implementing their family support plan (F.S.P.) or individualized educational plan (I.E.P.). Additionally, if the child requires related services such as speech, occupational or physical therapy, those specialists should be able to conduct therapies at the center.

The Individuals with Disabilities Education Act (IDEA) specifically addresses the educational needs of children with disabilities. Part C of this law addresses children birth to age three. Within Part C is the requirement that to the extent possible children birth to three should receive services in the "natural environment", which would include such places as the child's home, childcare center or family day care home, church or playgroup. Young children are especially eager to learn from one another; and seeing new skills modeled by a typically developing peer is an effective way for many young children with disabilities to learn.

To assist early childhood teachers in providing inclusive childcare the state of Florida has developed a program called the Special Instruction Consultant (SIC) service. In this model a trained professional will go into the childcare setting to assist the staff with classroom accommodations, the design of the learning environment and any technical assistance needed. This service is provided at no cost to both the family of the child with the disability and the childcare center but it must be listed on the child's family support plan. Currently, it is only available for children birth to three. The Special Instruction Consultant can serve as the bridge between the willingness of the caregiver to provide quality services for children and the actual delivery of these. It is important to remember and believe that children are more alike than different.

Materials

✓ Mitch Module Handouts:

  - Children who have special needs display one or more of the

following (Handout)
  - Definition of Terms used in P.L. 94-142 (Handout)
  - Risk Factors (Handout)
  - Suggestions for Observing (Handout)

- ✓ Walkabout questions - Four sheets of flip chart paper with the following headings:
  - I have had (this much) experience working with children with special needs – A lot; A little; None
  - Inclusion is …
  - Which disability would you be most comfortable having yourself?
  - What is special education?
- ✓ Three sheets of flip chart paper with the following headings:
  - Pre-Natal Risks
  - Peri-Natal Risks
  - Post Natal Risks
- ✓ Markers
- ✓ Video- Can I Play Too? Providers' version
- ✓ Video – Welcoming All Children: Inclusive Child Care

For additional resources see Book III: Special Instruction Consultant Manual

Teaching strategies

I. **Walkabout** (15 minutes) – Prior to the session the trainer should post the "Walkabout" questions on the walls around the training room. As participants come into the room ask them to walk around and answer the questions by writing their responses under the questions. Some questions only require a check mark, others require more thought. When everyone has had an opportunity to respond, the trainer should either read the answers aloud and lead a discussion, or ask the participants to read them to the group. The trainer can lead discussions regarding fears, misconceptions and experiences.

II. **Playing Favorites** (10 minutes) - Children who experience things differently may have what we call "special needs." However, we know that all children are special and that all individuals must be treated as special. Ask participants how many of them have children of their own. Wait for hands to rise. Call on one person and ask him or her to describe the children, and their ages. Ask that person, "When one of your children needed a new pair of shoes did all your children get a new pair of shoes?" Usually the answer will be, "No". Ask why. Usually, the answer will be that only one child needed the shoes. Explain that because they love their children they give them what they need, when they need it. And this is not "playing favorites", however it is treating each one of them in a special.

Give another example. Tell participants to think about their child's birthday party and to pretend that his favorite cake is chocolate. However, his best friend, who is coming to the party, is allergic to chocolate. Ask, "What might you do?" The answers might be, make two cakes, one chocolate and one vanilla or make cup cakes. Remark that these changes are not "playing favorites", they are merely accommodations you make due to the "special needs" of each child.

III. **Activity** (5 minutes) – Have participants take out their paper and a pencil or pen. Tell them they are going to do a very important task and to follow your instructions. Ask them to cross one leg over the other and start moving the top leg counter clockwise in a wide circle. Demonstrate this for them. They must continue doing this while they do the second part of the task. Now ask them to write their name in cursive as neatly as possible. After they have completed the writing sample, ask them to share their results by holding up the paper for others to see. The handwriting will probably not be very neat as it is difficult for the brain and body to process both of the tasks at the same time. Compare this challenge with the challenge of having a disability such as ADHD or a physical impairment such as cerebral palsy. Explain that it is often difficult for children with disabilities to complete what may seem to be a simple task because of additional challenges that they face.

IV. **Lecture – Presenter reviews handouts** (20 minutes)

1. The severity of problems children have range as follows: Mild, Moderate, Severe/Profound. Use a picture of a normal curve to visually show the range of "normal" and to depict the continuum of these ranges. Make sure to point out that every disability discussed above can be mild, moderate or severe to profound.
    - Severe/profound – These are the most obvious problems. Severely involved children are often easily identified as having disabilities at or soon after birth.
    - Moderate – This may or may not be as obvious as a severe problem
    - Mild – A mild problem is often the most difficult to detect because it is not as obvious as a moderate or severe problem. Many children who have mild impairments are not identified until they are in school. Then, difficulty with learning or keeping up with other children their age begins to appear.
2. Suggestions for Observing – Tell participants that it has been said that teaching is harder than being a pediatrician. Ask if anyone knows why. If no one answers, explain that pediatricians only see one child at a time, while teachers see

many children together. Also, a pediatrician can often write a prescription and the problem will be taken care of. Teachers cannot offer, such a "quick fix" for problems.

The teachers' ability to observe a group of children gives them a huge advantage over a pediatrician. That is, they can compare what is "typical" for most of the children in a specific age range. Discuss the handout "Suggestions for Observing" with the group.

V. Break (10 minutes)

VI. **Video** (30 minutes) – **Can I Play Too?** – View video with participants. Ask participants to write down one new idea or fact that they learn during the video. If time permits ask for volunteers to share their new idea with the rest of the group before the break.

VII. **Activity – Risk Factors** (20 minutes). Divide the participants into three groups. Ask each group to choose a recorder and a reporter. Each group will be discussing risk factors, those factors that are associated with a higher than average rate of disabilities in children. Group 1 (Prenatal) will list risk factors that can occur before birth that can affect a baby and cause or lead to a disability. Group 2 (Peri-natal) will list risk factors that can occur during the birth process that can affect a baby and cause or lead to a disability. Group 3 (Postnatal) will list risk factors that can occur after birth that can affect a baby and cause or lead to a disability. Note that some risk factors occur in the environments in which the child is developing and some may result from factors that affect others, such as parents.

After about 5 or 10 minutes, call everyone together into the large group and have reporters tell why or how these factors affect babies. Refer to the handout for a list of risk factors.

VIII. **Conclusion and Evaluation** (10 minutes) – Group leader can review major points and ask if there are any questions. When questions are finished hand out the evaluations. While participants are filling out the evaluation the group leader should write the date, time, location and topic of the next training session on the flip chart. Read the information aloud and collect the evaluation.

Activities to try at home or at the child care center:

✓ If your center does not already have children with special needs enrolled and you are interested in providing care for children with disabilities call your local Early Intervention Program and ask to be put on a referral list so that parents who are looking for care will know of your interest.

- ✓ Visit your local Early Intervention Program, agency programs that serve children with disabilities (such as Easter Seal, United Cerebral Palsy, ARC Project Thrive, and the Debbie Institute), or therapy providers that work with young children.

- ✓ If your center currently has children with disabilities enrolled find out from their families if they feel truly included. Are their children being invited to parties and other social events? Do they have friends that come to visit them? If not ask if the family would like to have you assist in arranging a "buddy family" who will include them in social events.

- ✓ If you are a parent make sure that your child has the opportunity to play with children who are different from him or her, either through race, ethnicity, religion, or disability. Teach tolerance and model it through your own actions.

References:

Gordon, J. (1993). *Can I Play, Too?* [Video]. Funded by The Partnership for Inclusion for the Frank Porter Graham Child Development Center, University of North Carolina, Chapel Hill, NC. Produced by Capital Media Center Raleigh , NC.

Molinet-Molina, M. & Estrada-Vidal, R. M. (1990). The Child Who Seems Different: Meeting Special Needs. "In C. F. Abbott & D. M. Fernandez (Eds.), *Mitch Module 3, Model of Interdisciplinary Training for Children with Handicaps: A Series for Caregivers of Infants and Toddlers.* Florida Department of Education. Division of Public Schools. Bureau of Education for Exceptional Students.

Children Who Have Special Needs

Display One or More of the Following

DEVELOPMENTAL DISABILITIES

Mental Handicap (Retardation) | Cerebral Palsy

Autism | Multiple Handicaps

SENSORY DISABILITIES

Hearing Impairments | Vision Impairments

PHYSICAL DISABILITIES

Orthopedic Impairments | Health Impairments

LANGUAGE DISABILITIES

Speech Impairments | Language Disabilities

BEHAVIORAL/EMOTIONAL DISABILITIES

LEARNING DISABILITIES

Adapted from ChildCare Continuum of Care

Module	Hour	Handout
3	1	1

Florida Department of Education
Division of Public Schools
Bureau of Education for Exceptional Students

*MITCH: Model of Interdisciplinary Training for Children with Handicaps

Definition of Terms Used in P.L. 94-142

FREE APPROPRIATE PUBLIC EDUCATION:

The words used in the federal law, P.L. 94-142, to describe an exceptional student's right to a special education which will meet his individual special learning needs, at no cost to his parents.

LEAST RESTRICTIVE ENVIRONMENT (LRE):

Part of the federal law and state law that deals with determining a handicapped child's placement. This includes that, to the maximum extent appropriate, handicapped children are educated with children who are not handicapped, and that the removal of a child from the regular school environment occurs only when the handicap is such that the child cannot be satisfactorily educated in regular classes with the use of aids and services. In choosing a child's placement in the least restrictive environment, possible harmful effects on the child and the quality of services he needs are considered.

Taken from: For Parents of Exceptional Students . . . An Information Series, published by The State of Florida, Department of Education (1982).

Module	Hour	Handout
3	1	2

Florida Department of Education
Division of Public Schools
Bureau of Education for Exceptional Students

MITCH*

*MITCH: Model of Interdisciplinary Training for Children with Handicaps

Risk Factors

BEFORE BIRTH

- drug abuse by mother
- alcohol consumption by mother
- poor nutrition of mother
- smoking by mother
- stress of mother
- genetic problems
- age of mother
- lack of prenatal medical care
- inadequate socio-economic conditions.

DURING BIRTH

- birth complication
- length of pregnancy
- position of baby during delivery
- size/weight of baby
- lack of medical care
- poor health of mother
- method of delivery.

AFTER BIRTH

- accidents (drowning, auto accidents, etc.)
- abuse
- lack of education
- lack of stimulation
- poor health habits
- lack of proper nutrition
- lack of love/care.

Module	Hour	Handout
3	1	5

Florida Department of Education
Division of Public Schools
Bureau of Education for Exceptional Students

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Suggestions for Observing

1. Watch the child in many different work and play settings.

2. Observe how the child gets along with other children in small and large groups.

3. Observe how the child responds to adults.

4. Consider cultural factors that may influence the child's behavior.

5. Observe what makes the child happy; what makes the child sad.

6. Observe whether the child acts older than others of the same age.
   Observe whether the child acts younger than others of the same age.

7. Watch to see if the child appears:
   - sad
   - tired
   - lethargic
   - stressed
   - oversensitive
   - overactive.

8. Observe changes in the child's behavior at different times of the day.
   If changes occur, what seems to cause the change?

9. Watch for clumsiness or lack of coordination.

10. Decide if the child seems to hear and see as well as other youngsters.

11. Observe whether the child seems to learn at the same, a slower, or a faster rate than others.

12. Determine how the child seems to learn best:
    - by watching
    - by doing (touching)
    - by listening.

13. Decide if the child communicates as well as others of the same age.

14. Decide if the child can care for personal needs as well as others of the same age.

15. Determine which methods of discipline work best for the child.

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Education of the Handicapped Amendments of 1986

Overview of P.L. 99-457

Coordinated Statewide System Will Strengthen Early Intervention Efforts for Infants and Toddlers

The 1986 Infants and Toddlers federal legislation has provided an exciting opportunity for Florida to create an integrated and coordinated statewide system for serving children during their very earliest years of life.

The primary intent of this legislation is to provide states with funds to plan and develop comprehensive systems of early intervention for infants and toddlers who are handicapped, developmentally delayed, or at risk of handicap or developmental delay and their families.

The law recognizes the growing body of research documenting the effectiveness of intervening on behalf of vulnerable children during the first 36 months of their lives. Conditions which may seriously impair a child's optimal development may be significantly improved if the right mix of services is available in a timely fashion.

The federal legislation provides incentives for states to:

Create a statewide system that links existing early intervention and family support systems into a more coordinated and cohesive system;

Coordinate existing funding to provide services to infants and toddlers, and enhance and expand the existing system of early intervention to infants and toddlers and their families.

In planning to implement P.L. 99-457 Part H, Florida recognizes that:

The family is the most important influence on a child, and the family should be an active participant in decisions affecting their child;

Each child is unique and has unique needs. Families also have unique characteristics and cultural differences which must be respected;

The child must be viewed in a larger context than that of the disability alone;

Eligible children are entitled to services that will support their physical, social, emotional, and intellectual development. Eligible children and families should, therefore, have access to the mix of services required to meet their individual needs;

Module	Hour	Handout
3	1	3

Education of the Handicapped Amendments of 1986

Overview of P.L. 99-457 (con't.)

Children have a right to a family-centered support system, including a service plan that addresses their unique needs, strengths, and capabilities;

Society benefits when children and adults achieve their maximum potential for independent living.

Florida has designated a lead agency, the Department of Education, to be the responsible agency for implementing the law. The Governor has appointed an interagency coordinating council with representation from parents, public and private providers, the Department of Health and Rehabilitative Services, and the Department of Education.

The federal legislation gives wide discretion to the states allowing them to define who will be eligible for services, the types of services available, and many other aspects of the system.

According to the federal legislation, by the fifth year, the statewide early intervention system must be fully implemented. Florida is currently planning activities, and efforts are underway to coordinate federal and state policies and to develop an integrated and coordinated statewide system.

If you would like more information about this effort, contact:

DOE Part H Coordinator
Prekindergarten Handicapped Programs
Bureau of Education for Exceptional Students
Division of Public Schools
Florida Department of Education
Florida Education Center - 544C
Tallahassee, FL 32399-0400
Phone (904)488-6830

or:

HRS Part H Coordinator
Department of Health and Rehabilitative Services
1317 Winewood Boulevard, Bldg. 5, Suite 188
Tallahassee, FL 32301
Phone (904)488-5040

Information on this sheet was compiled and written by Prekindergarten Handicapped Programs Office, Bureau of Education for Exceptional Students, Florida Department of Education

Module	Hour	Handout
3	1	3 (con't.)

Florida Department of Education
Division of Public Schools
Bureau of Education for Exceptional Students

*MITCH: Model of Interdisciplinary Training for Children with Handicaps

CHILD FIND

For Children who may need Special Education

Getting an education is every child's right. Children who are handicapped are no exception. This has been made extremely clear by the courts, state and federal legislatures and school boards throughout the country.

Child Find is looking for any person between the ages of 0-21 who may be handicapped and not receiving an appropriate education. Some of the handicapping conditions may be in the areas of:

SPEECH	HEARING	BEHAVIOR
LANGUAGE	VISION	GROSS AND FINE MOTOR SKILLS
RETARDATION	LEARNING	

If you are a parent or a friend of a potentially handicapped individual between the ages of 0-21, who is not enrolled in school or any other educational program, GIVE THAT CHILD A CHANCE!

CALL YOUR LOCAL CHILD FIND SPECIALIST: ____________________

AT: ____________________

Module	Hour	Handout
3	2	4

Florida Department of Education
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*MITCH: Model of Interdisciplinary Training for Children with Handicaps

The Enterprise Zone-Preschool Inclusion Project

Developmentally Appropriate Practices & Adapting the Classroom for Children with Special Needs

5

Developmentally Appropriate Practices And Adapting the Classroom

Major Concepts and Content

Many early childhood caregivers are familiar with the concept of Developmentally Appropriate Practices (DAP) as outlined in NAEYC's book of the same name. Children go through stages of development and the expectations that their caregivers have of them should be based on their level of development. In using DAP caregivers remain aware of the level each child is on and introduces, extends and scaffolds activities based on individual needs. This concept is easily adapted for use with children with special needs. Again, each child is seen as an individual and activities presented provide the child with the opportunity to learn new concepts. By being aware of the interests, strengths and abilities of each child caregivers can implement developmentally appropriate practices in the classrooms. Caregivers should also keep in mind that some materials or activities may need to be modified or adapted to fit a child's special needs. This decreases frustration on the part of the child while increasing the opportunities for interaction and learning from peers. Adaptations can be simple such as wrapping the handle of a spoon with layers of masking tape to make it easier to grasp or more involved such as a specialized switch that allows a child with a communication delay to make a choice between two options. It is important to make simple "low technology" adaptations first and then add the more specialized adaptations later to keep the child's experience as normalized as possible. Many people are fascinated with the "gadgets" that allow people with disabilities to fully participate and they should be introduced to these devices and given the opportunity to experiment with them if possible.

Materials

- ✓ Large Flip Chart Paper
- ✓ Markers
- ✓ Video "It's Really No Different: Conversations with Caregivers"
- ✓ Adapting the Environment for a Child with Special Needs (booklet)- 1 for each participant
- ✓ Clear plastic bags- gallon size- with toys and adaptations inside them (see Activity for detailed instructions and materials)
- ✓ Assistive Technology devices such as switch toys, hearing aids, augmentative communication devices or catalogues that illustrate the devices and how children use them (see resource list at the end of this section)

Teaching Strategies

I. **Introduction** (5 minutes)- Distribute name tags or have participants make name tents with large index cards and markers if they do not already know one another.

II. **Large Group Discussion: What are Developmentally Appropriate Practices?** (15 minutes)- Using the National Association for the Education of Young Children (NAEYC) book as your guide, review the principles of Developmentally Appropriate Practices (Bredekamp, 1990) with the group. Most early childhood caregivers have heard of this term and know what DAP means, however, it is always a good idea to review this important information. Tell participants that since DAP focuses on where the child is developmentally, it is logical that Developmentally Appropriate Practices for children with special needs also focuses on where they are developmentally. Ask them to break into small groups according to the age of the children they work with for the next activity. If they work with children in multi-age settings ask them to go to the group where they feel the most comfortable.

III. **Small Group Activity: Developmentally Appropriate Activities** (20 minutes) - Distribute large pieces of flip chart paper and markers to each group and ask them to come up with 4 activities that they do on a weekly basis with the children in their care. Have them write the name of the activity (e.g. finger painting) at the top of the paper and list ways that they can ensure that the activity is developmentally appropriate for their children. Then have them list the ways that the same activity could be developmentally inappropriate (e.g. telling the children who are finger painting not to mix the colors together). If time permits have each group share one activity with the large group.

IV. **Video: It's Really No Different: Conversations with Caregivers** (20 minutes) - Show videotape to participants and ask them to write down an example of a developmentally appropriate practice that they observed in the video.

V. **Break** (5 minutes)

VI. **Small Group Activity: Playing with a Disability** – (30 – 45 minutes, depending on group size) Tell participants to break into groups of 3 or 4 people and ask one participant from each group to come pick up a toy bag. Each bag will have a toy, game, or book inside with instructions. Each bag will also focus on a different disability. One person in the group should volunteer to be the child with the disability and the others can play as children or act as the caregiver. After the group has had an opportunity to explore the activity both as disabled and non-disabled participants the group leader can give a signal for them to rotate to the next activity. Encourage each group to come up with additional adaptations for the activities as they work on them and to explore the activity from the viewpoint of a child with a different special need than the one that is used in the sample bag. Detailed instructions follow. However, each trainer should feel free to make her own adaptations and suggestions.

Sample Instructions for "Playing with a Disability" Activity

Bag #1 - Child with a visual impairment

Simulation Materials: Bandana or mask that allows limited visibility.

Play Materials: 20 1-inch wooden cube blocks with instructions to "make a tower with all the blocks"

Adaptations: Larger size blocks or blocks with texture that allow for easy stacking. Instructions may be modified to "make a tower as tall as you can"

Bag #2 - Child with a physical impairment that limits use of fingers

Simulation Materials: Socks or mittens to put on hands

Play Materials: 10-piece puzzle with flat pieces with instructions to "put the puzzle together"

Adaptations: 10-piece puzzle with knobs or pegs that allow child to pick up pieces easily (you can make these by attaching pegs to the puzzle pieces with a hot glue gun or drilling a small hole in each piece then inserting the knob and gluing it for stability). Instructions can be modified to "play with the puzzle by lining up the pieces, naming the pieces, or playing with it in a different way"

Bag #3 - Child with a hearing impairment

Simulation Materials: Head phones or earplugs and instructions for other participants to speak very quietly or to talk without using their voice at all

Play Materials: Game such as Color and Shape BINGO that requires listening

Adaptations: "Non-disabled" participants should make sure that the "hearing impaired" participant can see their faces and get eye contact when they are speaking. They should speak one at a time and enunciate clearly. The "hearing impaired" participant can ask others to repeat themselves if she does not understand something. If any of the participants know sign language they can teach the others some simple signs for the shapes and colors of the BINGO game.

Bag #4 - Child with a large motor impairment that limits use of legs

Simulation Materials: Ace bandages, therapy bands or Velcro to wrap around both thighs of the "child with a disability" to limit her movement. Alternately, the person who is acting as the child with a disability can simply sit in a chair to participate

Play materials: Large rubber ball or beach ball, basket and instructions to play "basketball" with two teams of players

Adaptations: Use a larger basket to increase the possibility of the ball falling in the basket or change the game to "Catch" and don't use the basket at all. Use a scooter or chair with wheels to encourage the child with limited movement to move around. Change the activity entirely to an obstacle course where all children will get through it in their own way. This could include crawling, belly crawling, rolling, or scooting.

After all participants have had an opportunity to experience each activity ask them to come back to the large group and share their thoughts and feelings about adapting the environment to include children with special needs. Ask if any of them learned that it was easier than they expected or more difficult. Distribute the booklet "Adapting the Environment for a Child with Special Needs" and encourage them to use it in their classrooms or homes.

VII. **Experimenting with Assistive Technology** (10- 20 minutes) Even if you do not have access to expensive devices you can expose your participants to Assistive Technology. Low tech devices such as picture communication boards or crayons wrapped with masking tape to make them more stable are two examples of easy, inexpensive adaptations. If you have access to Assistive Technology devices through your local ChildFind office, Early Intervention Program, or classroom bring some of them to the session for participants to experiment with. Switch toys, augmentative communication devices such as Cheap Talk, and hearing aids are all interesting for participants to handle and experiment with. If you do bring these devices make sure that they are operating correctly prior to introducing them (check batteries and connections). Additionally, be sure to allow the participants to actually play with the equipment. It is frustrating for children and adults alike to watch someone else demonstrate the devices and not have an opportunity to use them. While assistive technology should not be the primary focus of a session on adapting the environment it does play an important role in increasing many children's functioning and increases the chances of successful inclusion. If there is an Assistive Technology specialist in your area you may want to invite her to share her expertise with the group.

VIII. **Conclusion and Evaluation** (5 minutes) - Conclude activity and ask if there are any questions. Hand out and collect evaluations and write the date, time, and location of the next training session where everyone can see it.

Resources for Adaptive Technology

☐ Abilities		
☐ Active Living Magazine	www.activelivingmagazine.com	905-957-6016
☐ Adaptivation Incorporated	www.adaptivation.com	800-723-2783
☐ Attainment Company	www.attainmentcompany.com	800-327-4269
☐ Enabling Devices	www.enablingdevices.com	800-832-8697
☐ IntelliTools	www.intellitools.com	800-899-6687
☐ Mayer-Johnson, Inc.	www.mayer-johnson.com	800-588-4548

References

Bredekamp, S. & Copple, C. (Eds.) (1997). Developmentally Appropriate Practice in Early Childhood Programs, Revised Edition. National Association for the Education of Young Children.

It's Really No Different: Conversations with Caregivers [Video], Available from AGH Associates, Inc. (609) 926-1316, ($65.00).

Peterson, E. A. (1998). Individualizing for Every Child: How your center can meet and surpass the Performance Standards requirements. *Children and Families,* Fall, *30-34*.

ADAPTING THE ENVIRONMENT
FOR
A CHILD
WITH SPECIAL NEEDS

As a care giver, adapting the environment for children with special needs may sound like a lengthy process; however, most children with special needs do not require special classroom arrangements or extra materials. It is actually quite easy to adapt and reorganize the materials already available. Basically, the classroom should be arranged to suit the ways in which it is normally used every day, with some minor modifications to suit the special needs of a child with special needs. This reference guide contains some suggestions for adapting the classroom environment.

This reference guide is produced by the Dade Association of Child Care Programs (D.A.C.C.P.) and is a collaborative effort between the D.A.C.C.P. and the University of Miami, Mailman Center for Child Development. It is funded through a State of Florida Early Childhood Development Grant.

ROOM ARRANGEMENT AND MATERIALS

Arrange the classroom so that all children can become as independent as possible.

1. Put step stools and stabilizing bars in bathrooms so that children can participate in toileting and hand-washing activities with minimal assistance.

2. Place materials on open shelves. Children need to be able to select books without help. Place some materials low enough so children who cannot stand can have access to them.

3. For children with visual disabilities, keep the room arrangement as consistent as possible. If anything is changed, be sure and tell the children - and show them. Use tactile markers to identify different sections of the room.

4. Store special equipment that is not being used out of sight.

5. Minimize crowding of children in different areas of the center to reduce behavior problems.

6. Select materials that encourage children to play together. Dramatic play activities, balls, wagons, blocks, telephones, doll houses, etc., all promote social interactions.

7. Provide duplicates of toys so that children with and without disabilities can learn from imitating each other.

8. Arrange seating so that children with and without disabilities sit next to each other.

9. Include books about children with disabilities in the book corner.

CARE GIVER BEHAVIOR

1. Praise children that are playing well together. Wait until they are finished to give the praise.

2. Pair children who have different skills and abilities. Put a talkative child with a child who has weak language skills.

3. Allow children with special needs to be the leaders when it is their turn to do so.

4. Respect children by not talking about them in front of other people. Never introduce a child by his disability - like - "Here is our cocaine baby".

5. Respect the rights of all children in permitting them to form friendships with both disabled and nondisabled children. Never tolerate teasing or cruelty.

6. Capitalize on the interest of children who are nondisabled to be friends with the children with special needs.

7. Teach all children simple sign language. Let everyone explore adaptive equipment. Allow Let them take toys to children with disabilities.

8. Focus on the child's abilities rather than disabilities.

VISUALLY IMPAIRED

1. Locate materials in an easily accessible spot.
2. Be prepared to increase or decrease the amount of light in parts of the classroom.
3. The child should be seated near an electrical outlet so that equipment such as a tape recorder may be used whenever necessary.
4. Be verbal, descriptive, and specific whenever addressing the child.
5. Seat the child especially close to movies, filmstrips, and picture books.

HEARING IMPAIRED

1. Speak in brief, complete sentences. Face the child and use visual cues such as hand gestures or pictures.
2. Use an overhead projector instead of a blackboard so that you may face the children as you speak.
3. Assign a "buddy" to assist the child with a hearing impairment to repeat directions and relay information that may have been missed.

PHYSICALLY IMPAIRED

1. Encourage acceptance and understanding by other children in the class by explaining what the child with a physical impairment child can and can not do.
2. Assign responsibilities and encourage independent functioning.
3. Clear wide, accessible paths throughout the classroom so that the child with physical impairments will not experience difficulty moving around.
4. It is important that the child be encouraged to participate in classroom activities as fully as possible.
5. Minimize the use of throw rugs in the center.

EMOTIONALLY IMPAIRED

1. Remove distractable stimulus providing an uncluttered area for the child.
2. Provide the child with immediate feedback and praise for good behavior.
3. Vary activities within a class period as well as day to day.
4. Use videos, tapes, and books whenever possible.

MENTALLY IMPAIRED

1. Structure brief, uncomplicated tasks.
2. Teach all activities in small steps.
3. Have a child practice a skill many times. In fact, "overlearning" the skill will aid his retention ability of that skill.
4. Provide for successful experiences as often as possible.
5. Always reinforce any amount of progress.

DEVELOPMENTALLY DELAYED

1. Give clear directions. Speak slowly, clearly, and use only a few words.
2. Physically move the child through a task so that the child can begin to "feel" what to do.
3. Avoid materials having confusing backgrounds.
4. Avoid changing activities abruptly.
5. Teach activities in small steps.

SPEECH/LANGUAGE IMPAIRED

1. Consult with therapist regarding student's specific problem and goals for therapy. Reinforce these goals in the classroom.
2. Be a good listener.
3. Give directions simply and in complete sentences.
4. Talk about what you are doing.
5. Talk about what the child is doing.
6. Have the child talk about what he/she is doing.
7. Repeat child's comment and add missing words.
8. Build on the child's comment by adding new information.

LEARNING DISABLED

1. Use short, one-concept phrases.
2. Give visual and auditory clues whenever possible.
3. Allow ample time for responses.
4. Provide opportunity for oral responses.
5. Seat student in least distracting area.
6. Provide a structured schedule for student.

HEALTH IMPAIRMENTS

1. Be fully informed about child's medication and your specific responsibilities.
2. Develop learning goals with child's therapist.
3. Make sure that the classroom is free of obstructions.
4. Plan your classroom arrangement so that "traffic routes" and activity areas are separated.
5. Keep your room arrangement as simple and uncluttered as possible.
6. Avoid placing noisy areas next to quiet areas.
7. Plan your day so that quiet activities are alternated between busy activities.
8. Avoid making child overly dependent on care giver.
9. Provide extra rest time if child requires it.
10. A health impaired child might have had fewer play experiences due to his condition. Therefore, help child learn how to share, take turns, and play in a group situation.

The Enterprise Zone-Preschool Inclusion Project

Behavior Management

6

Behavior Management

Major Concepts and Content

Parents and teachers of young children report behavior as one of the most important issues in their child's development. Infants and toddlers go through a series of stages that can leave their caregivers frustrated and bewildered. As babies grow they begin to assert themselves, often crying or even having tantrums if their needs are not met. Parents and other caregivers who learn behavior management and positive discipline techniques can assist their children in developing appropriate social skills, as they grow older.

Caregivers can avert many potential conflicts by carefully monitoring the environment and eliminating situations that could cause problems. Caregivers who set consistent rules and follow through with consequences will give young children the opportunity to succeed. Additionally it is important for parents and other caregivers to accept and describe young children's emotional states. Identifying how a child is feeling can help him to understand and cope with the emotion. Elementary school teachers suggest that good social skills, including the ability to control one's own behavior, are essential elements of school readiness.

Materials

- ✓ Behavior Fact Sheet (handout)
- ✓ Spanking, hitting, shaking; What to do instead (video for parent group)
- ✓ Flexible, Fearful, or Feisty: The Different Temperaments of Infants and Toddlers (video for caregiver group)
- ✓ Road Map of behavior management techniques (handout)
- ✓ Flip chart or chalkboard
- ✓ Markers or chalk
- ✓ Developing a Behavior Plan That Works (handout)
- ✓ Poster board with the following emotions written on it and a drawing or picture that represents each of the emotions: happy, sad, angry, tired, afraid, silly

Teaching Strategies

I. **Introduction** (10 minutes) – Presenter reviews Behavior fact sheet and promises participants that they will learn some possible new ways for dealing with behavior problems during the session. It is important for parents and caregivers to know that young children exhibit a wide array of emotions and that while these emotions are not always positive they should always be accepted. It is the behavior accompanying the emotions that may not be acceptable. For instance a child may feel angry that she is asked to share a toy. It is expected that she will feel this way but not acceptable for her to bite the child she is supposed to share with. Remind participants that young children have not yet learned how to identify and name their emotions and it is up to the caregiver to help them understand how they are feeling and what they can do about it.

II. **Animal Yoga Activity** (10 minutes) - Presenter asks all interested and able participants to come sit on the floor in a circle. Inform participants that they will be doing a few simple exercises that can help reduce stress, bring the energy level down in a group of rambunctious toddlers, reduce low back pain in caregivers, and make everyone laugh. Demonstrate and asks participants to sit with crossed legs (tailor style) and to put their hands in their laps. Tell participants to breathe in and out slowly and deeply with their eyes closed, and imagine that they are a small pond in the middle of a peaceful meadow. Ask participants what kind of animals might live in the pond. Wait for or suggest the following animals: fish, turtle, snake and frog.

Demonstrate the fish by lying down on your stomach with hands and arms by your side. Keep your legs straight behind you and your feet together. Arch your neck up slightly and wiggle your hands and arms like fins. Some fish may want to blow bubbles under the water.

Demonstrate the turtle by staying on your stomach but tucking your arms and legs under your body. Cover your head with your hands and pretend your hands and back are part of your shell. Peek out from under your shell and then tuck back under it.

The snake is similar to the fish but the hands are flat on the floor under your shoulders. Keeping the lower back and pelvis pushing towards the floor, slowly lift up the head, neck and upper back by pushing with the hands. Do not over extend! Slowly look over your shoulder to the left, then the right. Some snakes like to hiss and flick their tongues out.

For the frog position have everyone get into a squatting position with feet flat on the floor and hands dangling in front of the body. Gently bounce up and down in a jumping motion. Frogs may make a sound like "ribbit" or croak.

Participants may suggest other animals. Ask them to help demonstrate what that animal might do. Finally, ask all participants to come back to the crossed leg position, put their hands back in their laps and take another couple deep breath. Thank everyone for their participation and tell them that they can do these exercises alone, with their child or with a group of young children. The exercises can break up a circle time activity in which children are losing interest, and the spinal movements are very helpful to caregivers who are doing a lot of bending and lifting.

Note: This is an optional activity but it is very valuable in making caregivers aware of the importance of movement as a behavior management tool. Most participants report it as one of the favorite parts of this session and many of them carry on the activity with their own classes of young children.

III. **Group Activity** (20 minutes) – **Stop and Go-** Tell participants that they are going to get an opportunity to vent regarding all the frustrating behaviors that the children they care for may have. Draw a stop sign or just write the word "Stop" on the top left side of the flip chart or chalkboard. Then draw a circle with the word "Go" or just write the word "Go" on the top right of the flip chart. Now ask participants to call out all the behaviors that children do that they want them to stop doing. Expect a wide array including hitting, biting, swearing, hurting other children, screaming, crying, and tattling. List all the behaviors under the word "Stop". When everyone has had an opportunity to vent move to the right side of the chart and ask them to think about why the children are exhibiting these behaviors. It may take some time for them to come up with ideas about why children continue to do things that are inappropriate. Expect or prompt them with the following: seeking attention, developmental level, frustration, unable to talk to yet, want something and don't know how else to get it, imitating behavior they've seen elsewhere, exposure to violence at home or on television, pre-natal exposure to drugs or alcohol, have not learned an alternative behavior. When everyone has had an opportunity to share tell participants that you will be coming back to this activity in the second half of the session and leave it on the flip chart or chalkboard.

IV. **Video** (20 minutes) – **Flexible, Fearful and Feisty Temperament-** This tape presents the idea of temperament in infants and toddlers and relates temperament to behavior and group care. Use the segments on flexible, fearful and feisty infants and toddlers and ask participants to think about the children they care for and what temperaments they have.

V. **Break** (10 minutes)

VI. **Group Activity** –(15 minutes) **Road Map** - Hand out the Road Map to all participants and review the principles from the top left to the bottom and back to the top.

- ***Don't get physical*** - this is a reminder not to use physical punishment with young children. For those parents who still use physical punishment point out that what children are learning is that it is okay to hit when someone does something they don't like. If parents insist on spanking request that they do it as a last resort and ask them to consider the alternatives first.

- ***Have great expectations*** - if parents and teachers have negative expectations children will often live up to those expectations. Conversely, if parents and teachers expect children to have appropriate behavior and let children know exactly what is expected it is more likely that the children will behave in a positive way.
- ***Set up the environment*** - Many negative behaviors can be averted if the environment is set up to minimize conflict and misbehavior. Use safety items such as gates, outlet plugs, and latches to prevent children from getting into things they shouldn't. Provide doubles or multiples of favorite toys that toddlers may not be willing to share. Allow for plenty of time for both indoor and outdoor free play.
- ***No***! - Sometimes it's okay to say "no" to young children. As long as it is not overused and you mean what you say it's a good idea to let children know when something is definitely not permitted.
- ***It's the Rule*** - Children need to learn that there are rules and that rules must be followed. Make sure that everyone in the

home or child care center know what the rules are and agrees to them.

- ***Be Consistent*** - Once rules are made it's important that they are always implemented and that everyone has to follow them. For instance if children are not allowed to climb on the table they should not see an adult climb on a table to get something down from a shelf.
- ***Encourage*** - Notice when children are doing the right thing and acknowledge their efforts.

VII. **Small Group Activity** (30 minutes) **Developing a Behavior Plan That Works -** Presenter hands out "Developing a Behavior Plan" that works and asks participants to get in small groups or with a partner. Presenter reviews the steps in the plan and clarifies any questions. Tell participants to think of one behavior that a child has that they would like to reduce or stop. Remind participants to look at the behaviors and reasons listed in the "Stop and Go" activity. Have them go through the steps presented in the plan including identifying the behavior, looking for clues, reviewing the techniques they have already tried, and choosing a positive behavior they would like to see increased for every negative behavior they want to decrease. Remind them of the importance of sharing the plan with other people who interact with the child so that there is consistency in following through with the strategy they choose for at least one week. Tell them to be sure to record the number of times the target behavior occurs and the number of times they implement their strategy. The strategies can be drawn from the Road Map activity or from other suggestions they come up with within their small group. If there is time at the end of the activity ask one or more groups to share their process with the large group.

VIII. **Sign Language for Emotions** (10 minutes) - Presenter uses the poster board with pictures and labels of emotions to teach the group the sign language for the emotions. If the presenter does not already know the signs she may want to contact the local Deaf Services Bureau, a sign language interpreter or a teacher of the hearing impaired for instruction. Tell the caregivers that it is important to teach children to be able to identify how they feel and to label those feelings. By using sign language, even those children who cannot speak will be able to communicate how they are feeling to their caregivers and peers. Demonstrate and practice the signs with the participants and be sure to match the facial expressions with each sign. Remind participants that all feelings are okay and that it is our job to model to children how we can express our feelings appropriately.

IX. **Conclusion and Evaluation** (10 minutes) Ask participants to fill out and hand in the evaluations. Have the date, time, location and topic of the next session written on the flip chart and read it out loud to participants before they leave.

Activities to try at home or at the child care center:

- ✓ Try some of the animal yoga poses with the children you work with. Do them at different times of the day and see if you notice any changes in their behavior.

- ✓ Make a large poster of some of the basic emotions (see sign language suggestions). Display it in the home or classroom and point out to children how they appear to be feeling during the day.

- ✓ If there is a particularly challenging behavior problem that you are dealing with develop and implement a behavior plan. Ask an objective observer to watch you interact with the child for a period of time and then get feedback. You may unknowingly be contributing to the problem by your interactions with the child.

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EZ-PIs

Behavior

Positive reinforcement helps a child know what he is doing right.

Punishment focuses on what a child is doing wrong.

Babies respond positively to hugs, smiles, and touches. Toddlers also like hugs, smiles, and touches and they enjoy being praised and given rewards

Developing a behavior plan will help parent, teacher, and child deal effectively with problems.

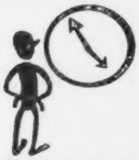
One of the best (but most difficult) ways of stopping behavior is to ignore it!

Change the environment to reduce problem behaviors; cover outlets, put gates on stairways, keep poisons out of reach and use car seats.

NEVER, EVER SHAKE A BABY. YOU COULD CAUSE BRAIN INJURY OR DEATH.

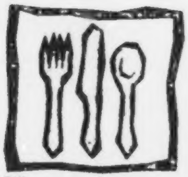
Rules of the Road

Don't get physical!



Be consistent.

Form positive relationships.

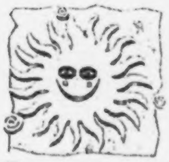


Have rules.

Just say "No".

Redirect misbehavior.

Model appropriate behavior.



Encourage and praise.

Managing Behavior in the Child Care Program

Developing a Plan that Works

This worksheet will help you develop a plan to manage behavior in your child care setting. As you complete each step you will be creating a plan that fits into your developmental philosophy and helps you organize your efforts to reduce or eliminate behaviors you have targeted as inappropriate.

1. **What is the target behavior?** Define the behavior as clearly as you can.

What: ______________________________

____

How often: ______________________________

How long: ______________________________

Who: ______________________________

Where: ______________________________

2. **Why is it a problem?** List two or three reasons why this particular behavior needs to be decreased.

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3. What strategies to decrease the frequency of this behavior have you already tried? Take a few moments to think through behavior management strategies you may have already used to manage this particular behavior.

The Strategy	Its Effect on the Behavior	Its Effect on You
A.		
B.		
C.		
D.		

4. What usually happens just before the target behavior occurs? Think about all the things that happened just before or while the target behavior occurred. Include the time of day, number of children, what the children were doing, what you were doing, etc.

5. Look for clues. Try to identify at least three reasons why you think this behavior occurs.

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6. Choose at least one behavior to increase for every behavior you want to decrease. Select one behavior that you would like to increase and describe how you will do that in the space below.

7. Plan your strategy. Describe the strategy you have chosen.

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8. **Tell the players.** List the other people who will help you implement this plan.

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

9. **Be consistent.** Record the following information for three days:

	Day 1	Day 2	Day 3
How many times did the target behavior occur?			
How many times did you implement your plan correctly?			
How many times did you reinforce the behavior you have chosen to increase?			

10. **Is it working?** Try for at least a week to consistently respond to the target behavior using the strategy you outlined. Then use the space below to record how well you think your plan is working, any changes you need to make, or other strategies you would like to try.

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The Enterprise Zone-Preschool Inclusion Project

Intellectual Development: What You Can Do to Help

7

Intellectual Development: What You Can Do To Help

Major Concepts and Content

To support learning it is helpful to know where students have been, where they are likely to be going, and where they are presently. Development is concerned with changes that occur over time. Developmental sequences are fixed and universal. Growth and development are different concepts. Growth refers to increase in height, weight or physical size. Development is the refinement, the improvement or expansion of an existing component or skill. Development can refer to the mind, the emotions, or the body.

During the preschool years the developmental areas that are typically assessed include cognitive development, which include language development, motor development, social, and emotional development and self help development. These areas are interrelated and interdependent. Consequently, it is important to view each individual or child as an indivisible totality. It is not possible to foster development in one area at the expense of the others. To appropriately support cognitive development in children there is an implicit need to support development in all other areas.

We all have our own assumptions of what intelligence is. When the public in general has been asked, "What is intelligence?" they have for the most part agreed on three areas: practical problem solving ability, verbal ability and social intelligence (Kamphaus, R. W., 1993). However, what we refer to as intelligence psychologist refer to as cognition. Cognition refers to the process by which knowledge is acquired and manipulated. The processes involve interpreting, organizing, storing, coordinating, retrieving, and using information received from the internal and external environment, that is, the processes of thinking and memory. Therefore, cognitive development refers to age related differences in thinking. Specifically, children's cognitive development refers to the child's ability to gather and use information or to learn.

When we speak of language development we refer to the child's ability to receive (understand) and deliver (express) information. It also implicates speech, gestures, signs, facial expression and body attitude. Motor development is divided into fine motor and gross motor. Fine motor development refers to the child's ability to use and coordinate small muscles for fine, precise movements, mostly involving the hands. On the other hand, gross motor development refers to the ability to coordinate and use muscles in the arms and legs (large muscles).

The other two areas that are commonly assessed in preschoolers are social emotional and self-help development. Social emotional development looks at the child's ability to relate and interact with other persons in the environment. Self-help development looks at the child's ability to take care of personal needs.

Materials

- ✓ Overhead projector
- ✓ VCR and monitor
- ✓ Flip Chart and Easel
- ✓ "4 straight lines" (Activity sheets Handout)
- ✓ Video –Discoveries of Infancy: Cognitive Development and Learning
- ✓ The following Mitch Module handouts and/or transparencies:
  - The Total Child
  - Definition of Terms
  - Developmental Skills
  - Principles of Development
  - For Caregivers of Infants (Piaget's stages of Development)
  - Suggested Toys and Equipment for Infants
- ✓ Sample LAP-D, SIB-R, VMI and BASC protocols (See reference for complete names and information)
- ✓ Multi-sensory props:
  - carrot erasers for prizes
  - plastic carrot
  - carrot puzzles
  - carrots

- pop-up bunny book
- photos of carrots
- planter with carrots growing
- other carrot-related stimuli

Teaching Strategies

I. **Introduction: "4 Straight Lines"** (10 minutes) – Hand out the activity sheet titled "4 Straight Lines" to participants. Ask participants to solve the puzzle. After they have had a chance to work on a solution show those who were not able to figure it out how it can be completed. Drawing lines that reach outside of the area formed by the 9 dots solve the puzzle. This emphasizes the concept of "thinking outside the box". Encourage participants to approach the concept of understanding how a preschooler's mind perceives the world by thinking outside of the adult's frame of reference.

II. **Key Concepts: The Total Child** (20 minutes) - Using the transparency "The Total Child", introduce the 4 areas of development typically assessed in children. Use the transparency named "Developmental Skills" to further explain and clarify these 4 areas and to give examples of each.

   1. **Language Development**: If the instructor speaks another language (such as Spanish) that some of the participants understand and some do not, he may (without introduction) hold up a plastic carrot,

describe it in Spanish and then ask a simple question (such as the color of the carrot) in Spanish. Next, call on one of the participants who seem not to understand, and ask him/her for the answer. If the participant does not understand, call on a participant who does understand. When the correct answer is given, refer back to the original participant and chide him/her (in English) for not listening. Next, ask him/her a second question (in Spanish), repeat the process of getting a correct answer from someone who understands and chiding the participant who "was not listening". Discuss the feelings of frustration and/or embarrassment that the participant might feel to how a child with a language delay would feel in the classroom. Encourage teachers to be conscious and supportive of language-delayed children.

Introduce the concepts of receptive and expressive language. Note how deficits in one area may produce deficits in the other areas.

2. **Motor Development:** Hand out copies of a difficult page of the Developmental Test of Visual-Motor Integration (VMI) protocol. Have participants attempt to accurately copy the figures in a short period of time. Point out how motor-delayed children would have just as much difficulty copying simple figures. Relate this to the difficulties visually motor delayed children experience in normal classroom functioning.

3. **Social and Emotional Development:** Introduce this concept of development. Give hypothetical examples of children in a class who have behavioral problems. Ask teachers to suggest possible developmental delays that may lead to that undesirable behavior. Examples of this might include expressive speech difficulties leading to a child's taking another's objects by force rather than asking, or receptive language difficulties contributing to a child's short attention span and the subsequent propensity to get off task or bother other students during longer verbal tasks or activities. The Behavior Assessment System for Children (BASC) protocol can be used to identify areas of delay in social and emotional development.
4. **Self-help Development:** Introduce this concept of development. Distribute copies of the Scales of Independent Behavior-Revised (SIB-R) protocol and go over the items to illustrate concrete examples of the self-help skills that develop at the different ages. Give examples of how delays in this area could affect development in other areas.

It is important that the presenter stress how each of the areas of development is interrelated to the other areas. Give examples of how a delay in one area may cause delays or difficulties in other areas of development. After suggesting a hypothetical developmental delay in a child, ask participants to give an example of related delays or deficiencies that may occur in other areas of that child.

III. **Video – Discoveries of Infancy: Cognitive Development and Learning** (20 minutes) – View the video with the participants. Highlight the importance of early care and its subsequent effect on lifetime development.

IV. **Break** (10 minutes)

V. **Key Concepts: Principles of Development** (10 minutes) - Use the transparency titled Principles of Development, to introduce the 6 principles. The Learning Accomplishment Profile Diagnostic Edition (LAP-D) protocols can be used to illustrate some of the principles.

Present the transparencies titled "For Caregivers of Infants" and "Suggested Toys and Equipment for Infants". Use these transparencies to provide examples of developmentally appropriate activities and toys.

VI. **Developmental Disabilities and Mental Retardation** (15 minutes) – Define the concepts of developmental delay and mental retardation and clarify the differences between the two. Children develop at different rates. Each child is unique and achieves his or her milestones at different times. It is important to understand that for each milestone, there is a range of ages during which the child will normally attain the skill. Some sit by 6 months of age, others at 4 months, and still others at 8 months. Some walk early, and others walk late. Therefore, one must be cautious of these varying rates of development before deciding if a child presents a delay. Developmental delays occur when a child presents a delay in the attainment of one or more milestones. Delays in development are determined by comparing a child's development in the areas of cognitive, motor, social and personal skills to other same-age children's development. Delays must exist in more than one area to be considered a problem.

On the other hand, mental retardation is a term used when a person has certain limitations in mental functioning and in skills such as communicating, taking care of him or herself, and social skills. These limitations will cause a child to learn and develop more slowly than a typical child. They will take longer to learn to speak, walk, and take care of their personal needs. Eventually, they will begin to have problems learning at school. The diagnosis of mental retardation is obtained by looking at the person's ability to learn, think, solve problems and make sense of the world (intellectual functioning), and at the person's ability to live independently.

Additionally and if time permits, the presenter may want to review with participants the instruments used to assess intellectual functioning and adaptive skills (e.g. Weschler Preschool and Primary Scale of

Intelligence, Scales of Independent Behavior – Revised). The discussion may include a description of the tests, the names, and the interpretation of the scores.

VII. **Teaching Children with Developmental Delays (15 minutes)** - Explain that in order to effectively teach students with developmental delays it is important to use a variety of methods to approach the same topic. For example, if a teacher wants to teach about a topic such as *carrots,* that teacher may use a variety of media and methods. Set up centers with the different materials. Give participants the choice to select the center they would prefer to participate in, but limit the number of participants per center. Once a center is filled up explain that they can choose from the remaining available centers. Rotate among the centers until everyone has had a chance to participate in all of the activities. Set up the centers with the following activities: (These are just some suggestions)

- Different carrot puzzles with varying levels of difficulty, and textures
- Books, pictures and photos of carrots
- Read to a small group a book about a rabbit that likes carrots or any story that talks about carrots, such as *The Carrot Seed*.
- Plant carrot seeds in a planter (students would track the carrot growth)
- Pass around a plastic carrot and have participants give one related word to describe the carrot
- Make carrot snacks and/or give each participant a baby carrot to eat

- Do an art activity with stamps made out of carrots
- Give carrot-shaped erasers as prizes for well-done work or participation
- Other activities as time allows

VIII. **Homework assignment** (5 minutes) - Participants are given a description of a child who seems to have a developmental delay. Each participant is asked to develop a lesson plan that would teach a specific concept in a way that would be particularly effective to the delayed child.

IX. **Conclusion and Evaluation** (10 minutes) - Presenter reviews the major points and asks for questions. When questions are finished, hand out the evaluations. While participants are filling out the evaluations write the date, time, location and topic of the next training session. Read the information aloud and collect the evaluation.

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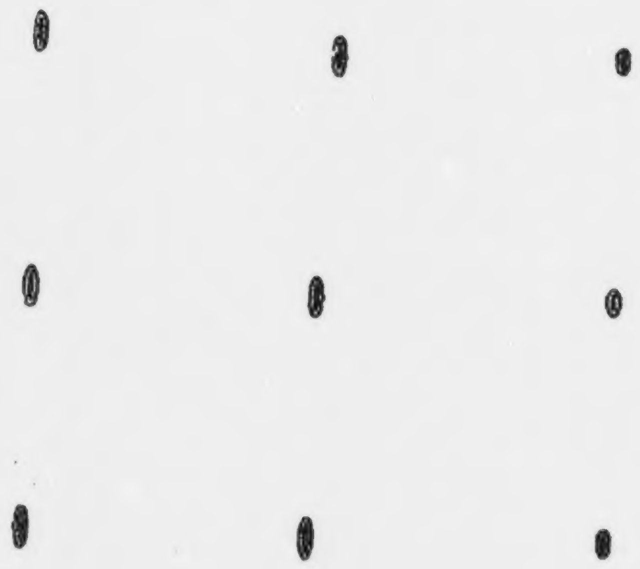
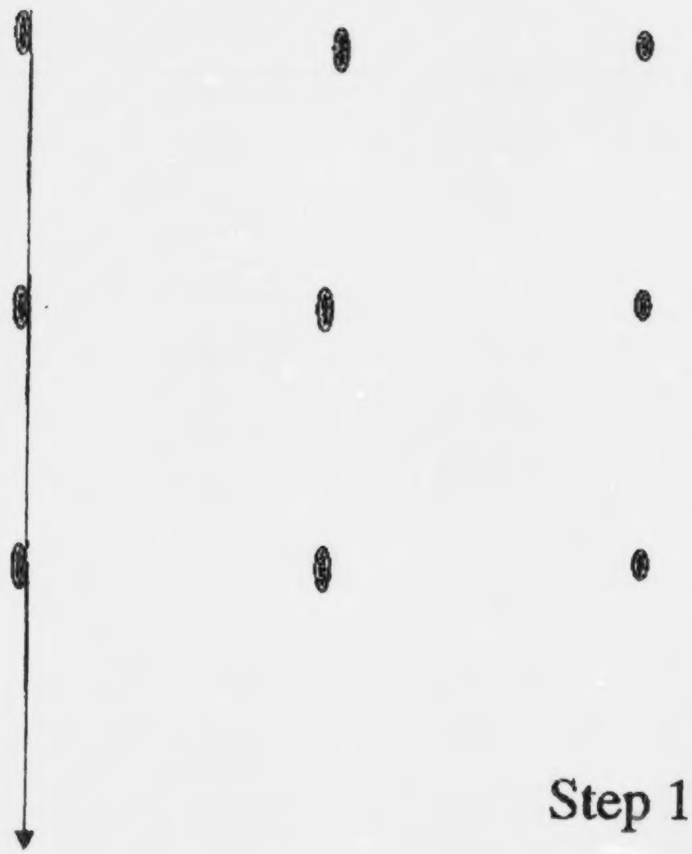
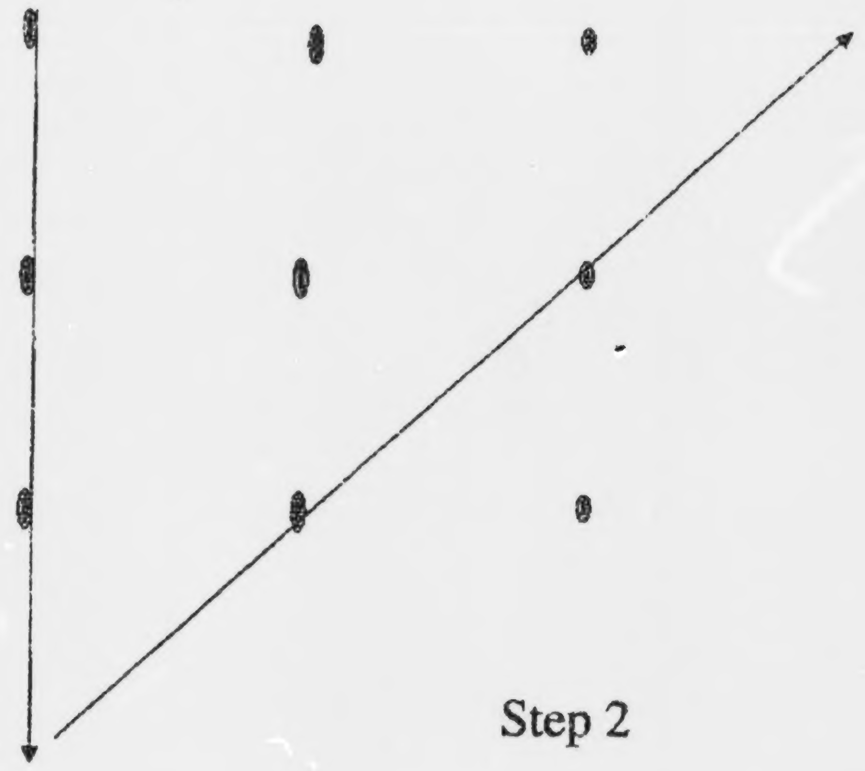
“4 Straight Lines” Activity

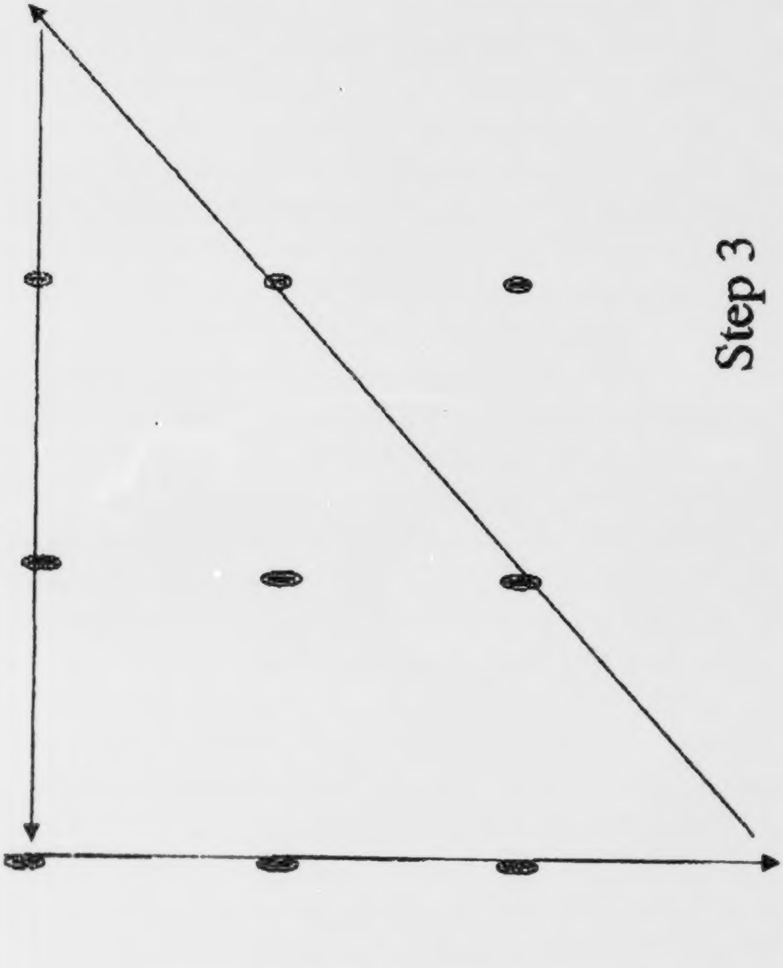


Can you connect all nine dots by using just 4 lines without picking up your pencil?

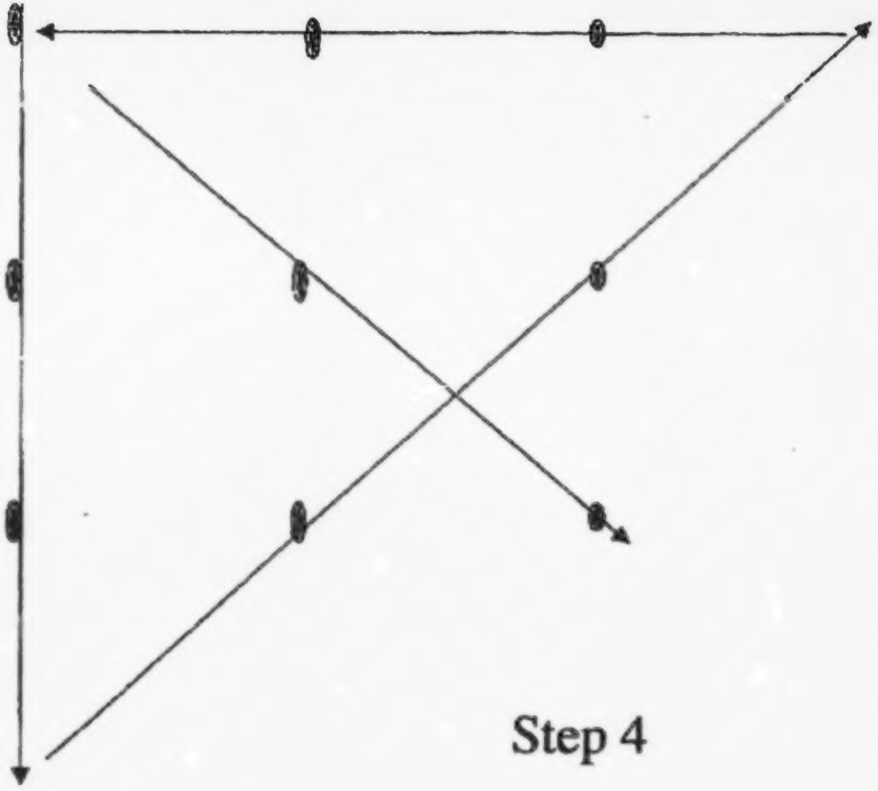


Step 1





Step 3



Step 4

Definition of Terms

1. **Age-Appropriate Activities:** activities suitable to the child's age and developmental level.

2. **Behavior:** the way a person acts.

3. **Behavior Modification:** techniques for changing the way in which a person acts.

4. **Characteristics:** special traits or features that identify one from others.

5. **Concept:** an idea or an understanding.

6. **Development:** progression from earlier to later stages of individual maturation or growth.

7. **Discipline:** a positive learning experience. It is a method of teaching children acceptable behavior and/or self control.

8. **Emotional Development:** gradual orderly growth of a child's feelings and personality; closely connected to social development.

9. **Environment:** social and cultural conditions that affect growth and development.

10. **Genetic:** inherited.

11. **Growth:** progressive development.

12. **Guidance:** way in which adults help children learn to control their actions and make decisions.

13. **Heredity:** the passing on of physical/mental characteristics from parents to their children.

14. **Intellectual (Cognitive) Development:** gradual orderly growth of a child's knowledge and logical thought; closely connected to language.

15. **Language Development:** gradual orderly growth of the ability to communicate; closely connected to intellectual development.

16. **Motor Development:**

    Fine Motor Skills involve actions that use the small muscles of the body such as those of the hands/fingers.

    Gross Motor Skills involve actions that use muscles of the body such as those of the arms and legs.

17. **Physical Development:** growth and stature of the body.

18. **Play:** an important way in which children learn.

Module	Hour	Handout
1	1	1

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Definition of Terms (con't.)

19. **Punishment:** to subject someone to a penalty for misbehavior.

20. **Reflexes:** an automatic, involuntary and often inborn response to a stimulus.

21. **Self Concept:** how an individual feels about him or herself.

22. **Self-Help Development:** gradual orderly growth of basic living skills; feeding/toileting/dressing.

23. **Sensory Development:** development of the senses (taste, touch, smell, hearing, vision).

24. **Social Development:** gradual orderly growth of a child's sense of self and attachments to other people; closely connected to emotional development.

THE TOTAL CHILD

Intellectual (Cognitive) Development Involves Language

Self-Help Development

Social and Emotional Development

Motor Development (Gross/Fine)

Module	Hour	Handout
1	1	2

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DEVELOPMENTAL SKILLS

Areas Typically Assessed in Preschool Children

1. Intellectual (Cognitive) Development: Intellectual or cognitive development refers to the child's ability to gather and use information, or to learn.

Learning involves the active interplay between what the child perceives (sees, hears, tastes, touches, smells) and what the child already knows (memory). This interplay is further affected by the child's language ability, emotional state, and environment.

Evaluation of learning, or cognitive development, involves looking at the mental processes that make possible such intellectual, or school-type skills, as sorting, grouping, and classifying. Traditionally, it has been less concerned with "non-intellectual" or everyday-type skills such as being able to find one's way to a friend's house, taking a bath, or painting a picture.

Evaluation is usually done by a psychologist who uses "Intelligence Tests," such as the Merrill Palmer Scale of Mental Tests, Leiter International Performance Scale, Stanford Binet Intelligence Scale: Edition IV, Kaufman Assessment Battery for Children, McCarthy Scales of Mental Abilities, and the Wechsler Preschool and Primary Scale of Intelligence.

2. Language Development: Language development refers to the child's ability to receive (understand or comprehend) and deliver (express or give out) information. In addition to speech, it involves gestures, signs, facial expression and body attitude.

Language is the major method of communication. It is the way a child tells us what the child wants us to know. It is the way a child knows what we want the child to know or do. Therefore, language is also the process by which a child gains information or knowledge. The child uses language to order and name his world. Language is used to elaborate concepts and ideas. Language is heavily tied to learning and cognitive development.

Evaluation of speech and language is usually done by a speech and language specialist, although language is also evaluated by a psychologist. Common tests are the Peabody Picture Vocabulary Test, the Expressive One Word Picture Vocabulary Test, the Preschool Language Scale, and the Sequenced Inventory of Communication Development.

3. Fine Motor Development: Fine motor development refers to the child's ability to use and coordinate small muscles for fine, precise movements, mostly involving the hands.

It is necessary for a child to have good skills in this area in order to engage in appropriate interaction with materials such as paper and pencil, blocks, puzzles, buttons, snaps, zippers, and shoe laces. Good fine motor skills helps or harms a child's ability to learn from the environment. They also affect a child's ability to perform tasks at an age appropriate level.

Module	Hour	Handout
1	1	3

DEVELOPMENTAL SKILLS (con't.)

Fine motor skills may be evaluated by psychologists or teachers using certain sections of developmental tests such as the Learning Accomplishment Profile, Diagnostic-Revisted; or the Battelle Developmental Inventory. There are also special tests to evaluate eye-hand coordination such as the Developmental Test of Visual Motor Integration. More in-depth evaluations may be done by occupational therapists.

4. Gross Motor Development: Gross motor development refers to a child's ability to coordinate and use muscles in the arms and legs.

It is necessary for a child to have good skill in this area in order to run, walk, sit and find correct position in space. Correct positioning directly affects a child's fine motor ability, and consequently directly impacts the child's degree of success with toys and materials.

Evaluation of gross motor skills can be done by psychologists or teachers using developmental tests (see above). In-depth evaluations may be done by physical therapists.

5. Social and Emotional Development: Social and emotional development refers to a child's ability to relate to and intereact with other persons in the environment.

This area includes the child's feelings of self-worth, how the child approaches a problem, what the child expects from others, the level of understanding the child has of self, and the awareness the child has of the thoughts and feelings of others.

Evaluation of social and emotional development may be done by teachers, social workers, psychologists and, sometimes psychiatrists. They may use one or more checklists or scales, such as the Burk's Behavior Rating Scale or the Vineland Adaptive Behavior Scales. Sometimes social workers, psychologists or psychiatrists will look at a child's drawings or evaluate a child by using a clinical interview (talking with the child and/or watching the child play).

6. Self-Help Development: Self-help development refers to a child's ability to take care of personal needs such as feeding and dressing. These are learned behaviors that are influenced by such factors as the child's mental ability, the home environment, experience and physical abilities.

Evaluation of these skills can be done by teachers, social workers, or psychologists. They use checklists and scales (see above) and special sections of developmental tests (see above).

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Module	Hour	Handout
1	1	3 (con't.)

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PRINCIPLES OF DEVELOPMENT

Normal development is not random.

Development is similar for all infants/children.

Development proceeds from general to specific responses.

Development is continuous.

Development matures at different rates.

Development is interrelated.

Module	Hour	Handout
1	1	4

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FOR CAREGIVERS OF INFANTS
WHO ARE FUNCTIONING DEVELOPMENTALLY IN THE BIRTH TO 12 MONTH RANGE

When a child can . . .	We should . . .	WHY? . . .
USUALLY AT 0-3 MONTHS		
Follow objects with eyes	Provide mobiles, mirrors, bright objects, and familiar adult faces	
Respond to sound by turning head or other body movements	Provide musical mobiles, rattles, radios, and familiar adult voices	
Express demands with cries	Respond to cries and attend to basic needs. No danger of "spoiling baby"	
Look to face when spoken to	Talk to in soothing voice tones placing adult face 10-18 inches from baby's face	
Grasp objects when put in hand	Provide small handled rattles, hanging mobiles, and "adult touches"	
Look rapidly between two objects in sight	Provide mobiles, bright objects, mirrors, and adult faces to stimulate	
USUALLY AT 3-6 MONTHS		
Look at own hand/finger move; objects held in own hand	Provide opportunity for free body movement; assist in self-discovery by placing baby's hand, foot in visual range through games, etc. Also place rattles, toys in baby's hands	
Pick up objects using a two-hand approach to grasp toys; put objects to mouth	Provide handled rattles and other safe objects for small grasp; encourage mouth motions and awareness of hands, fingers, arms, feet, and toes	

Module	Hour	Handout
1	2	1

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MITCH*

*MITCH: Model of Interdisciplinary Training for Children with Handicaps

FOR CAREGIVERS OF INFANTS WHO ARE FUNCTIONING DEVELOPMENTALLY IN THE BIRTH TO 12 MONTH RANGE

When a child can . . .	We should . . .	WHY? . . .
Repeat hand or leg movements to keep toy moving	Provide hanging toys, swinging mobiles, and crib gyms	
Turn head toward sound of voice and follows speaker	Talk to baby, varying sound/tone and distance/location of voice	
Bang toys in play	Provide pots/pans, wooden spoons, rattles, blocks, and other toys. Stimulate child by adult modeling banging in play	
Show response to simple action games through simple movement responses	Play patty-cake, peek-a-boo, bye-bye, and other simple action games	
USUALLY AT 6-9 MONTHS		
Transfer objects from hand to hand	Provide small blocks, rattles, toys, etc. for grasping and releasing. Hand child a second toy when he already has one in hand	
Look for and pick up toys dropped/partially hidden	Play game dropping/hiding toy. Play peek-a-boo. Provide small grasp toys, blocks, balls, and other put-together and take apart toys	
Reach for toys with one hand	Provide small toys, blocks, and objects suitable for grasping	
Imitate simple actions and sounds	Play simple games pairing words with action such as bye-bye, patty-cake, dog-ruff, ruff	
Recognize name when called	Play simple games, calling child's name. Sing "Where is Tommy? Where is Tommy? Here he is, here he is! Tommy, Tommy, Tommy"	

Module	Hour	Handout
1	2	1 (con't.)

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FOR CAREGIVERS OF INFANTS WHO ARE FUNCTIONING DEVELOPMENTALLY IN THE BIRTH TO 12 MONTH RANGE

When a child can . . .	We should . . .	WHY? . . .
Show interest in effects of motor actions	Provide toys that children can act upon, such as pop-up, pull string, busy boxes, etc. with space for exploration and use of toys	
USUALLY AT 9-12 MONTHS		
Look for objects out of sight	Provide pop-up toys, busy boxes, blankets, and boxes for hiding toys	
Put things in and out of containers	Provide filling and dumping toys, such as blocks in a bucket, sorting toys, cups, blocks, and pails.	
Show interest in pictures	Provide large, colorful pictures and books of familiar animals, toys, people; talk about pictures providing names	
Enjoy rhythm	Provide musical toys, records. Model simple imitation of body movements to music, clapping hands and singing songs, sounds	
Grasp small objects with thumb and one finger	Provide small objects, such as raisins, cereal for child to pick up	
Take lids off, put in large pegs and remove stacking disks	Provide stacking toys, jar with lids, pegboard, pegs	

Remember: There is a wide range of individual abilities in the development of young children.

NOT ALL CHILDREN WILL DO ALL THINGS AT EXACTLY THE SAME TIME.

Module	Hour	Handout
1	2	1 (con't.)

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FOR CAREGIVERS OF INFANTS
WHO ARE FUNCTIONING DEVELOPMENTALLY IN THE BIRTH TO 12 MONTH RANGE

When a child can . . .	We should . . .	WHY? . . .
USUALLY AT 0-3 MONTHS		**TO ENCOURAGE:**
Follow objects with eyes	Provide mobiles, mirrors, bright objects, and familiar adult faces	increasing attention to movement; eye movement
Respond to sound by turning head or other body movements	Provide musical mobiles, rattles, radios, and familiar adult voices	listening and following of sounds
Express demands with cries	Respond to cries and attend to basic needs. No danger of "spoiling baby"	establishing a sense of well being and postive adult/child relationship
Look to face when spoken to	Talk to in soothing voice tones placing adult face 10-18 inches from baby's face	attending to adult face; early social interaction skills
Grasp objects when put in hand	Provide small handled rattles, hanging mobiles, and "adult touches"	grasping and body awareness
Look rapidly between two objects in sight	Provide mobiles, bright objects, mirrors, and adult faces to stimulate	attending to more than one object visually and visual tracking
USUALLY AT 3-6 MONTHS		**TO ENCOURAGE:**
Look at own hand/finger move; objects held in own hand	Provide opportunity for free body movement; assist in self-discovery by placing baby's hand, foot in visual range through games, etc. Also place rattles, toys in baby's hands	attending visually to objects, body awareness; tactile experiences
Pick up objects using a two-hand approach to grasp toys; put objects to mouth	Provide handled rattles and other safe objects for small grasp; encourage mouth motions and awareness of hands, fingers, arms, feet, and toes	aiming and grasping; hand to mouth motion; body awareness; eye-hand coordination; oral stimulation
Repeat hand or leg movements to keep toy moving	Provide hanging toys, swinging mobiles, and crib gyms	associating movement with effect; cause things to happen; motor actions
Turn head toward sound of voice and follows speaker	Talk to baby, varying sound/tone and distance/location of voice	tracking of sounds and attention to adult voice; positive communication

Module	Hour	Handout
1	2	2

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FOR CAREGIVERS OF INFANTS WHO ARE FUNCTIONING DEVELOPMENTALLY IN THE BIRTH TO 12 MONTH RANGE

When a child can . . .	We should . . .	WHY? . . .
Bang toys in play	Provide pots/pans, wooden spoons, rattles, blocks, and other toys. Stimulate child by adult modeling banging in play	bringing objects to mid-line; eye-hand coordination
Show response to simple action games through simple movement responses	Play patty-cake, peek-a-boo, bye-bye, and other simple action games	imitating in a social context, motor control and awareness
USUALLY AT 6-9 MONTHS		**TO ENCOURAGE:**
Transfer objects from hand to hand	Provide small blocks, rattles, toys, etc. for grasping and releasing. Hand child a second toy when he already has one in hand	practicing of grasp and release in midline play; eye-hand coordination
Look for and pick up toys dropped/partially hidden	Play game dropping/hiding toy. Play peek-a-boo. Provide small grasp toys, blocks, balls, and other put-together and take apart toys	relating to others; visual attending; awareness that objects still exist when spatially hidden
Reach for toys with one hand	Provide small toys, blocks, objects suitable for grasping	increasing eye-hand coordination; purposeful action
Imitate simple actions and sounds	Play simple games pairing words with action such as bye-bye, patty-cake, dog-ruff, ruff	imitating in social context; use and meaning of language; body awareness and control
Recognize name when called	Play simple games, calling child's name. Sing "Where is Tommy? Where is Tommy? Here he is, here he is! Tommy, Tommy, Tommy"	Knowing own name; self awareness; meaning of language
Show interest in effects of motor actions	Provide toys that children can act upon, such as pop-up, pull string, busy boxes, etc. with space for exploration and use of toys	increasing awareness of making things happen; purposeful motor action

Module	Hour	Handout
1	2	2 (con't.)

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FOR CAREGIVERS OF INFANTS
WHO ARE FUNCTIONING DEVELOPMENTALLY IN THE BIRTH TO 12 MONTH RANGE

USUALLY AT 9-12 MONTHS		TO ENCOURAGE:
When a child can . . .	**We should . . .**	**WHY? . . .**
Look for objects out of sight	Provide pop-up toys, busy boxes, blankets, and boxes for hiding toys	increasing permanence of objects and people; purposeful actions
Put things in and out of containers	Provide filling and dumping toys, such as blocks in a bucket, sorting toys, cups, blocks, and pails.	beginning concept of space perception; attending to a task; eye-hand coordination
Show interest in pictures	Provide large, colorful pictures and books of familiar animals, toys, people; talk about pictures providing names	increasing visual attending and vocabulary; understanding meanings of words/pictures
Enjoy rhythm	Provide musical toys, records. Model simple imitation of body movements to music, clapping hands and singing songs, sounds	moving of body to music; simple imitation of sound and actions
Grasp small objects with thumb and one finger	Provide small objects, such as raisins, cereal for child to pick up	use of pincer grasp; eye-hand coordination; directed actions
Take lids off, put in large pegs and remove stacking disks	Provide stacking toys, jar with lids, pegboard, pegs	coordinating two hands; eye-hand coordination; space perception

Remember: There is a wide range of individual abilities in the development of young children.

NOT ALL CHILDREN
WILL DO ALL THINGS
AT EXACTLY THE SAME TIME.

Module	Hour	Handout
1	2	2 (con't.)

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Suggested Toys and Equipment for Infants

1. Toys for Babies Who Are Tuning In

- Mobiles
- Mirror toys
- Toys that attach to the side of the crib which encourage visual exploration
- Rattles - small handle ("dumbbell" type rattle)
- Velcro rattles (attach to baby's wrists and ankles)
- Squeeze toys (soft and pliable)
- Crib Gym
- Puppets
- Brightly colored socks for hands and feet
- Musical toys (soft musical animals, wind-up TV and radio)
- Beach ball (for relaxation and encouraging lifting of head)

2. Toys for Babies Who Are Reaching Out

Language

- Baby telephone
- Books (sturdy pages with large, simple pictures)
- Jack-in-the-box
- Dolls and stuffed animals
- Puppets

Solving Problems

- Roly-poly toys (hard plastic and inflatable)
- Musical Instruments (using hands to make sounds on toy piano, drums, etc.)
- Busy boxes
- Rattles and squeeze toys
- Pull toys

Motor

- Balls (clutch balls, soft cloth balls)
- Crib gym
- Large beach ball
- Punch balls and other hanging items (streamers, wind chimes)

3. Toys for Babies Who Are Making Discoveries

Language/Imaginative Play

- Dolls
- Books
- Play hats
- Stuffed animals
- Plastic animals
- Plastic dishes and cookware
- Toy telephone
- Cars and trucks
- Small playhouse with little people and furniture
- Puppets and finger puppets

Motor

- Rocking toys (vestibular stimulating and sitting balance)
- Riding toys
- Balls (all shapes and sizes)
- Pull toys
- Push toys (chime sounding, corn popper)
- Punch balls

Solving Problems

- Filling and dumping toys (with large pieces)
- Inset puzzles (begin with one piece with large knobs, circles, simple shapes)
- Shaper sorter
- Pounding toys (encourage use of tools)
- Scarves and boxes (for "hiding" toy games)
- Water toys (things that sink, float, pour, and sprinkle)
- Musical instruments (using hand or tool like a wooden hammer or spoon to make sounds)

Module	Hour	Handout
1	2	3

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The Enterprise Zone-Preschool Inclusion Project

Speech and Language Development

8

Speech and Language Development

Major Concepts and Content

A child's first words are an important event for parents and caregivers all over the world. Language is both listening (receptive) and talking (expressive), and toddlers and preschoolers need ample opportunity to listen and to practice babbling or talking. Our positive and patient reactions let them know that we value their attempts at communication. Young children experience an explosion of language ability in their second year of life. Their constant pointing and questioning, "What's that?" will enable them to learn more words at age two than at any other time in their life.

Parents and caregivers do not need to formally teach language. Talking, singing, and reading all offer opportunities for stimulating language growth. Research is also showing that children can easily learn more than one language when they are young and they may learn to speak without an accent. For those who are concerned that learning a second language will confuse the young child, the recommendation is that separate people speak separate languages. For instance, mother would only speak Spanish while the caregiver at school would only speak English to the child. Of course, it is important that all who care for the child can communicate with one another to facilitate sharing information about the child.

Parents and teachers are often concerned with the language development of their children. In this session the normal developmental process of language acquisition will be introduced. Participants will also gain knowledge into atypical language development and when to be concerned about a child's language skills. The material presented in this session is based upon information from *MITCH Module 2 Model of Interdisciplinary Training for children with Handicaps* (1990), one of eleven training models that have been developed.

The first segment focuses on the definition of communication, the articulators of the speech mechanism and the mechanical process by which speech is produced. A brief overview of the ear is followed by a review of the stages of language development and milestones from birth to 6 months of age. The session then continues with speech and language developmental milestones from 7 months to 24 months of age.

The focus of the last part consists of a discussion on what to expect from a child who is learning to use words and how to identify "red flags" that signal that language development may be atypical or delayed. This is followed by a discussion of how to access services. Augmentative/alternative communication strategies are briefly discussed for the non-verbal or developmentally delayed child. Given the cultural diversity in our area, bilingualism is also addressed.

Materials

- ✓ Overhead projector
- ✓ VCR and Monitor
- ✓ Flip chart or chalkboard
- ✓ Mitch module handouts:
    - ▪ Definition of Terms
    - ▪ Infant Sounds
    - ▪ Receptive and Expressive Language – Stages
    - ▪ Language Growth
    - ▪ Ways to Talk to a Toddler
    - ▪ Red Flag Behavior
    - ▪ Module 2, Hour 2, Handout 9 (Transparency)
    - ▪ Module 2, Hour 2, Handout 10 (Transparency)
    - ▪ Schematization of the anatomy of the speech and respiratory mechanism
- ✓ Vocabulary, Speech Sound and Sentence Development Handout
- ✓ Video: "Raising America's Children: Listening and Talking"
- ✓ Marker or chalk and eraser

- ✓ Standardized test of expressive vocabulary to demonstrate standardized testing format
- ✓ Presenter's personal videos demonstrating examples of children with varying communication difficulties with and without known etiologies (i.e., developmental delay vs. neurogenic communication disorder).

Teaching Strategies

I. **Introductions** (20 minutes) – Speaker presents an overview of the information that will be covered and provides objectives for the session. The content of the handouts is briefly reviewed. Participants are informed that visual materials will be used in conjunction with the lecture throughout the 2-hour session to reinforce and clarify concepts. Specifically, the presenter will show videotaped segments demonstrating "typical" and "atypical" speech and language development. Case examples will be discussed to highlight specific speech and/or language disorders as well as intervention strategies. Participants are encouraged to raise questions regarding specific children in their facilities with regard to language or speech concerns. Activities are included to facilitate learning.

II. **Activity** (10 minutes) - After the speaker has presented an overview of the contents of this session, have the participants break up into pairs, picking a partner that they have not met prior to this session. They introduce themselves to one another, and exchange some personal information (i.e., name, place of birth, something about themselves). The speaker then discusses the components of an effective communication exchange and how communication occurs. A discussion of the pragmatics of communication and differing cultures' rules of communication are also addressed.

III. **Discussion** (30 minutes) **Language Development** - Presenter discusses 4 phases of speech production (respiration, phonation, resonation, and articulation). Instructions are given to demonstrate vegetative breathing in contrast to speech breathing. Use the overhead projector The content is presented with videotapes interspersed to demonstrate typical development from birth to 6 months. Participants are asked to identify early prelinguistic behaviors in the children that they observe in the videotape.

A discussion of language milestones achieved by each child with respect to receptive and expressive language development is presented accompanied with videotaped segments of the typically developing child. The participants follow along in their handouts to assist them in identifying these milestones in the videotaped segments. Lexical acquisition, early semantic-syntactic relationships, and early grammatical structures are discussed.

Activities for facilitating language development for caregivers and parents are discussed.

IV. **Break (10 minutes)**

V. **Activity** (10 minutes) - Using a flip chart to record the participants' responses, the presenter shows a picture of an object that might be unfamiliar to a young child (i.e., fireplace). The participants are asked to pretend that they are between the ages of 3½ - 5 and are told to identify the object w/o naming the actual picture. This is to demonstrate how children with a limited lexicon may "over generalize" or describe features of an object when they don't have an adequate lexicon. Also, discuss articulation or speech sound development according to the developmental norms.

VI. **Discussion of "atypical" language and speech development** (15 minutes) - Using segments from the presenter's videotape lead a discussion regarding "atypical" language and speech development. Use case examples to highlight specific disorders as well as intervention strategies.

VII. **Activity** (15 minutes) – Ask participants to divide into two equal groups. Two overheads are shown (Module 2, Hour 2, Handout 9) and (Module 2, Hour 2, handout 10). These overheads are used to facilitate a discussion of ways to encourage or discourage communication in a young child. Each group chooses a group leader who serves as the recorder for the group. The participants in one group prepare a list of concrete ways to enhance and promote communication in a child. The other group prepares a list of things that discourage a child to talk. The presenter then records each group's responses on a flip chart for the entire group to view.

VIII. **Conclusion and Evaluation** (10 minutes) – Review the major points and ask if there are any questions. After concluding with the discussion hand out the evaluation. While participants fill out the evaluations write the date, time, location and topic of the next training session on a flip chart. Read the information aloud and collect the evaluations.

References

Raising America's Children: Listening and Talking. To borrow a copy contact the Clearinghouse/Information Center, Bureau of Education for Exceptional Students, Florida Department of Education, 622 Florida Education Center, Tallahassee, FL 32399-0400; phone (904) 488-1879, Suncom (278-1879), or from any local FDLRS Associate Center. To purchase a copy, contact DC/TATS MEDIA, Frank Porter Graham Child Development Center, University of North Caroline at Chapel Hill, CB 8040, 300 NCNB Plaza, Chapel Hill, NC 27599-8040; phone (919/962-7358).

Vanderbilt Research and Training Center on Communication Disorders in At-Risk Children. (1993). *Speech and Language Delays: What Do They Mean for Your Child?* [Video]. Nashville, TN: Bill Wilkerson Center Press. (Available from Bill Wilkerson Center Press, 1114 19th Avenue South, Nashville, TN 37212, phone 615-320-5353, 800-369-4191.

Vergara, K., Lewis, B. & Weissler, L. (1990). Speech and language development what you can do to help." In C. F. Abbott & D. M. Fernandez (Eds.), *Mitch Module 2, Model of Interdisciplinary Training for Children with Handicaps: A Series for Caregivers of Infants and Toddlers.* Florida Department of Education. Division of Public Schools. Bureau of Education for Exceptional Students.

Definition of Terms

ARTICULATORS	Those parts of the face, mouth and throat that create the sounds of speech, either by controlling the flow of air or shaping the space it travels through.
AUDIOLOGY	The science of hearing and hearing disorders including the assessment of hearing impairment and treatment.
BABBLING	Prelinguistic infant vocalizing beginning at about 4 months of age.
COCHLEA	A spiral tube of the inner ear resembling a snail's shell which contains the sensory mechanism of hearing.
COMMUNICATION	The expression of ideas, information, or feelings by any system; conveying meaning.
COMMUNICATION DISORDER	An impairment of one's ability to understand or express ideas, information, or feelings.
COOING	Infant vocalizing indicative of comfort or pleasure, usually in response to caretaker's smiles or talk, at about 6 to 8 weeks old.
DEVELOPMENT	The progression from earlier to later stages of maturation or from simpler to more complex stages of evolution.
HAIR CELLS (Cilia)	Sensory receptors found in the cochlea of the inner ear.
HANDICAPPED	Limited by physical or mental impairment. One with two or more disabilities would be multiply handicapped.
HEARING IMPAIRMENT	A loss of hearing ability ranging from slight to profound.
LANGUAGE	A structured, mutually accepted, symbolic method of expressing and communicating thoughts and feelings, vocally or graphically, used for interpersonal communication.
OTITIS MEDIA	Otitis is inflammation of the ear. Otitis media is inflammation of the middle ear.
PARALLEL TALK	A clinician's narration of what the client is experiencing or doing; a clinician's exact repetition of what the client has said.

Module	Hour	Handout
2	1	1

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Definition of Terms (con't.)

PHONEME	One of a set of acoustically distinctive speech sounds, each corresponding to one of the symbols in the phonetic alphabet, and each distinguishing one utterance from another in a given language.
PRAGMATICS	The development of language in relation to the context and environment in which it originates. Relationships and intentions between speaker and listener, and all of the environmental elements surrounding the message.
SCREENING	A gross measuring or testing of subjects to separate into groups those who need attention for a specific condition and those who do not.
SELF-ESTEEM	The description of an individuals' self-concept, self-evaluation, or self-worth.
SENSORINEURAL	Pertains to the process of conveying sensation to nerves or to nervous tissue.
SIGN LANGUAGE	A method of communication for the deaf in which gestures replace words.
SPEECH	A method of oral communication using a code of language (oral symbols) to express thoughts and feelings and to understand others using the same language.
SPEECH AND LANGUAGE PATHOLOGIST	An individual, appropriately educated in speech and language pathology, qualified to diagnose speech, language, and voice disorders and prescribe and perform therapy related to those disorders (also called clinicians, therapists).
STUTTERING	Speaking with a spasmodic hesitation, prolongation, or repetition of sounds due to a disturbance in the normal fluency and timing of speech. The mechanisms involved in these dysfluencies may be neuromuscular, respiratory, phonatory, or articulatory.
VOICE	In speech, the sound produced by the expiration of air through vibrating vocal cords and resonated within the throat and head cavities.
WH QUESTION	An inquiry (question) that begins with "wh", such as, who, what, why, where, when, which, and whose.
WORD	A sound, or combination of sounds (or its graphic representation) that symbolizes or communicates a meaning, and consists of one or more phonemes and one or more syllables.

Module	Hour	Handout
2	1	1 (con't.)

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INFANT SOUNDS
(Expressive Language)

Birth to 6 Months

Vegetative Sounds

- grunts
- sucking
- burps
- sighs
- yawns

Non-Vegetative Sounds

- hunger and discomfort cries
- coos
- raspberries
- squealing
- goos
- gurgles
- laughter

Module	Hour	Handout
2	1	11

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RECEPTIVE LANGUAGE - STAGE II

7 to 12 Months

At 7 to 8 months a child will:

- look in the direction of speaker when the child's name is called
- raise arms when someone reaches toward child
- look at familiar people (mother-father-caregiver) when that person is named
- respond to noises and voices by making gross motor movements.

At 9 to 10 months a child will:

- momentarily stop an activity when hearing "no-no" or own name, then resume the activity
- discriminate among familiar voices (e.g., mother, father, or caregiver)
- begin to attend to a few familiar words (e.g., child's name, "daddy," "bye-bye")
- respond to "bye-bye" by smiling or crying.

At 11 to 12 months a child will:

- like to listen to words
- demonstrate an interest in environmental noises
- give a toy upon request when accompanied by a gesture
- follow simple spoken commands with gestures (e.g., "sit down," "stand up," "come here," etc.).

Module	Hour	Handout
2	2	2

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EXPRESSIVE LANGUAGE - STAGE II

7 to 12 Months

At 7 to 8 months a child will:

- laugh out loud
- respond appropriately to a friendly or angry voice
- vocalize displeasure other than crying (i.e., screaming, whining, etc.).

At 9 to 10 months a child will:

- imitate speechlike sounds
- imitate simple motor acts (i.e., clapping)
- babble to people
- use a two-syllable babble
- shake head for "no"
- babble phrases (4 syllables or more)
- imitate the number of syllables
- produce sounds which sound like words
- increase verbal output with direct verbal stimulation.

At 11 to 12 months a child will:

- say first true word used appropriately, with meaning, and on a consistent basis
- begin to imitate non-speechlike sounds (i.e., tongue clicking)
- use different melody patterns
- babble monologues when alone
- repeat sounds or actions if laughed at previously
- demonstrate a peak usage of sound repetitions
- try to sing
- vocalize in a repetitive fashion
- play with and imitates own sound.

Module	Hour	Handout
2	2	3

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RECEPTIVE LANGUAGE - STAGE III

13 to 18 Months

At 13 to 14 months a child will:

- begin to understand own name, the names of toys, family members, and clothing
- respond to simple noun words.

At 15 to 16 months a child will:

- discriminate among familiar noises (e.g., telephone, doorbell, vacuum)
- find a baby in a picture when asked
- recognize hair, mouth, nose and hands when they are named.

At 17 to 18 months a child will:

- respond to simple commands without gestures (e.g., "Put the ball on the chair," "Get Mom your shoes")
- identify two objects in a box
- enjoy picture books
- listen to rhymes or songs for several minutes.

Module	Hour	Handout
2	2	5

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EXPRESSIVE LANGUAGE - STAGE III

13 to 18 Months

At 13 to 14 months a child will:

- demonstrate a speaking vocabulary of at least three words in addition to "mama" and "dada"
- begin to engage in a vocal/verbal exchange.

At 15 to 16 months a child will:

- use 4-7 words appropriately
- use expressive jargon (strings of sounds having a melody and sounding like sentences)
- leave off the beginning and ending of words or change consonants
- indicate wants by pointing and vocalizing
- name a few familiar objects.

At 17 to 18 months a child will:

- use twenty words appropriately
- speak in a telegraphic manner (use one or two words to mean whole concepts - "eat" may mean "I want to eat!")
- imitate simple motor acts consistently
- combine words relative to needs (e.g., "eat cookie," "drink juice").

Module	Hour	Handout
2	2	6

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EXPRESSIVE LANGUAGE

19 to 24 Months

At 19 to 24 months a child will:

- engage in sing-song word play
- use make-believe words
- imitate and repeat what child hears
- inconsistently use favorite words
- utilize overextension
- utilize telegraphic speech
- make requests
- name objects
- use possessives
- ask questions.

RECEPTIVE LANGUAGE

At 19 to 24 months a child will:

- understand time concepts
- comprehend concept of sharing
- understand cause and effect
- follow directions.

LANGUAGE GROWTH - Stage V

24 to 36 months

At 24 to 36 months, a child will use:

- full sentences
- past, present, future tense
- plurals, possessives
- WH questions
- prepositional phrases
- pronouns
- modifiers
- negatives
- contractions
- conjunctions.

Ways to Talk to a Toddler

Positive:

- Look at the child and bend down to the child's level if possible.
- Get the child's attention and speak naturally.
- Speak in short simple sentences about things that are important in the child's world.
- Respond to the child's words as clearly as possible.
- Be patient and listen to what the child says.
- Tell the child you understand the child's feelings.
- Read to the child. This is a great way to share language and start conversations.

Negative:

- Don't ask the child to repeat the same words again and again. Do try to understand by asking a question such as, " . . the dog what?"
- Don't tease the child about how the child speaks.
- Don't ignore the child.
- Don't threaten or bribe the child. ("If you don't say this word, you can't have a cookie.")
- Don't talk for the child. Let the child try, and help the child.

Module	Hour	Handout
2	2	12

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RED FLAG BEHAVIOR

Signs of a Possible Speech/Language Problem

Stage I **0 to 6 Months:**

- Baby does not seek out or maintain eye contact.
- Baby does not respond to sound by startling or moving eyes and head.
- Baby is very quiet; does not coo, goo, make raspberries, squeal, or generally play with sounds.
- Baby has difficulty eating.
- Baby rarely or never plays turntaking games by smiling, laughing, gooing.

Stage II **7 to 12 Months:**

- Baby does not start babbling.
- Baby does not understand own name.
- Baby does not recognize parents, caretakers by sight.
- Baby does not understand the names of a few familiar objects (e.g. bottle, shoe).
- Baby continues to have many ear infections.

Stage III **13 to 18 Months:**

- Baby does not like to play with toys.
- Baby has not started to use the same sounds or words to get what baby wants.
- Baby shows no desire to communicate/interact with others.
- Baby cannot coordinate/imitate mouth movements for speech sounds.

Module	Hour	Handout
2	3	5

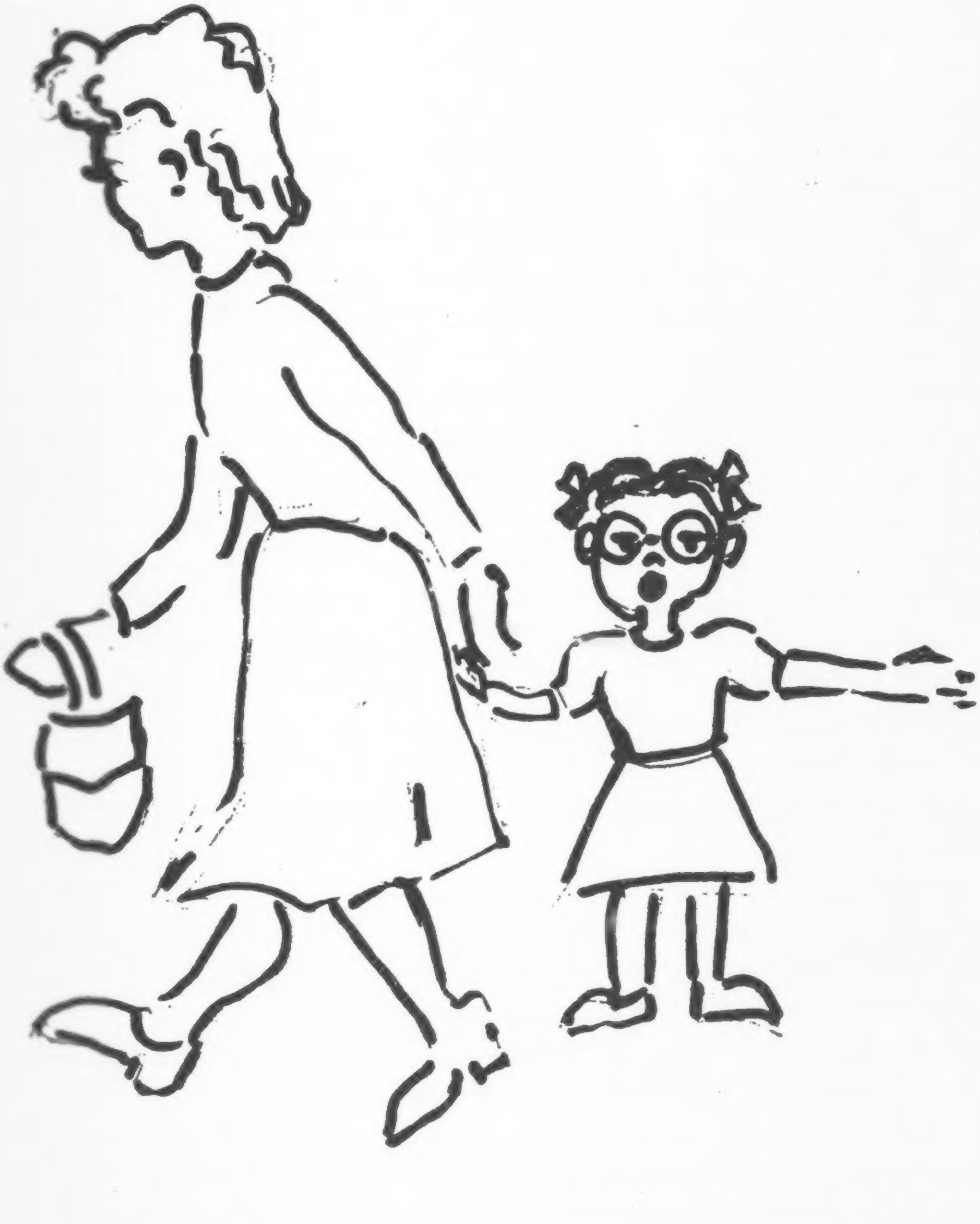
Signs of a Possible Speech/Language Problem

Stage IV **18 to 24 Months:**

- Toddler does not label or ask about things in the environment.
- Toddler talks but cannot be understood.
- Toddler cannot follow one-step directions.
- Toddler is not learning new words.

Stage V **24 to 36 Months:**

- Toddler does not put 2-3 words together into short sentences.
- Toddler uses words and sentences that do not make sense or relate to what the child is doing.
- Toddler has voice that is always hoarse.
- Toddler says "What?" or doesn't appear to hear consistently.
- Toddler does not remember names for things.
- Toddler displays speech that is very "stuttered".
- Toddler does not pay attention to any activity for very long.
- Toddler mixes up words in sentences.
- Toddler cannot follow two-step directions.



Module	Hour	Handout
2	2	9

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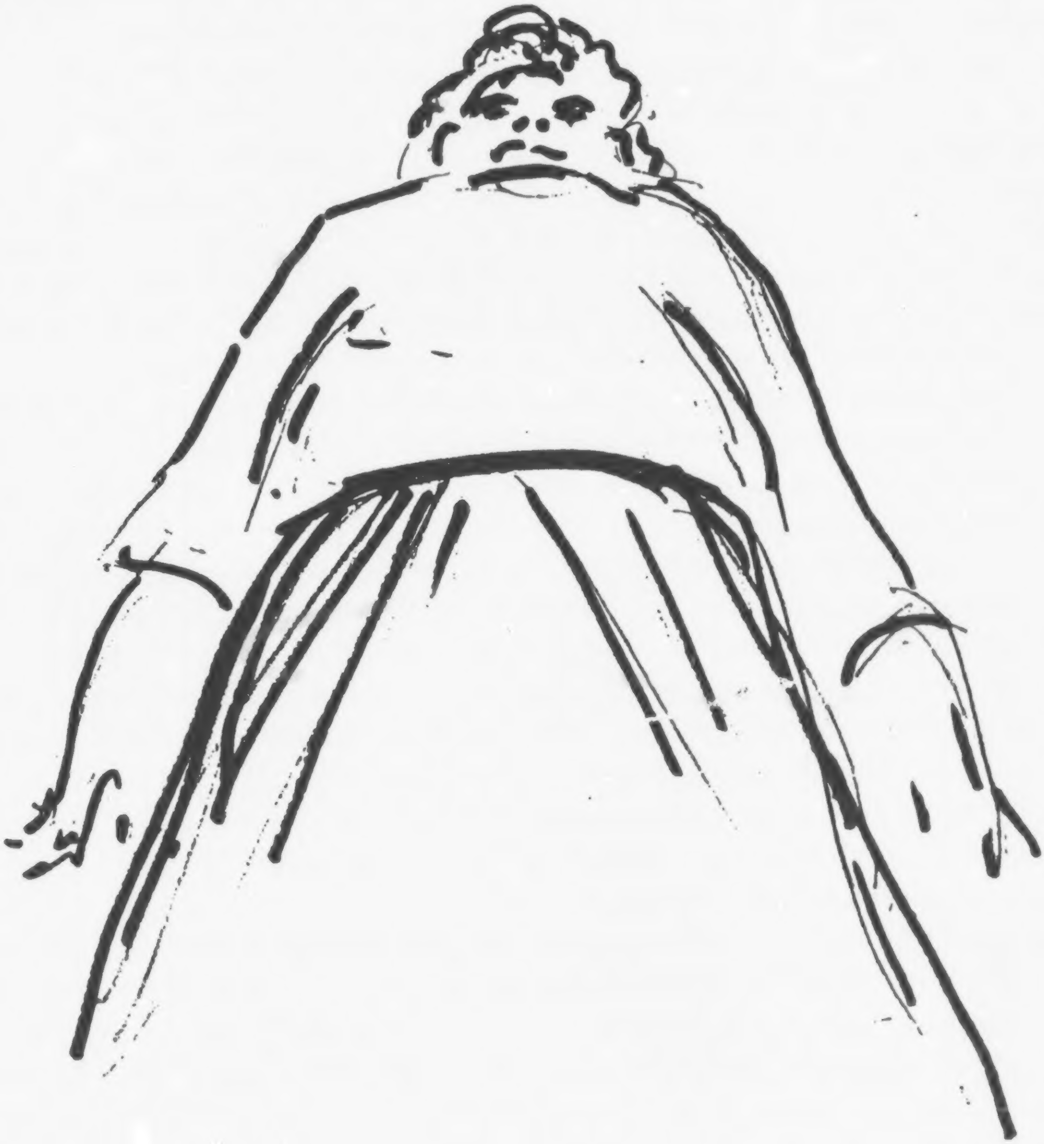
*MITCH: Model of Interdisciplinary Training for Children with Handicaps

MITCH*



Module	Hour	Handout
2	2	10

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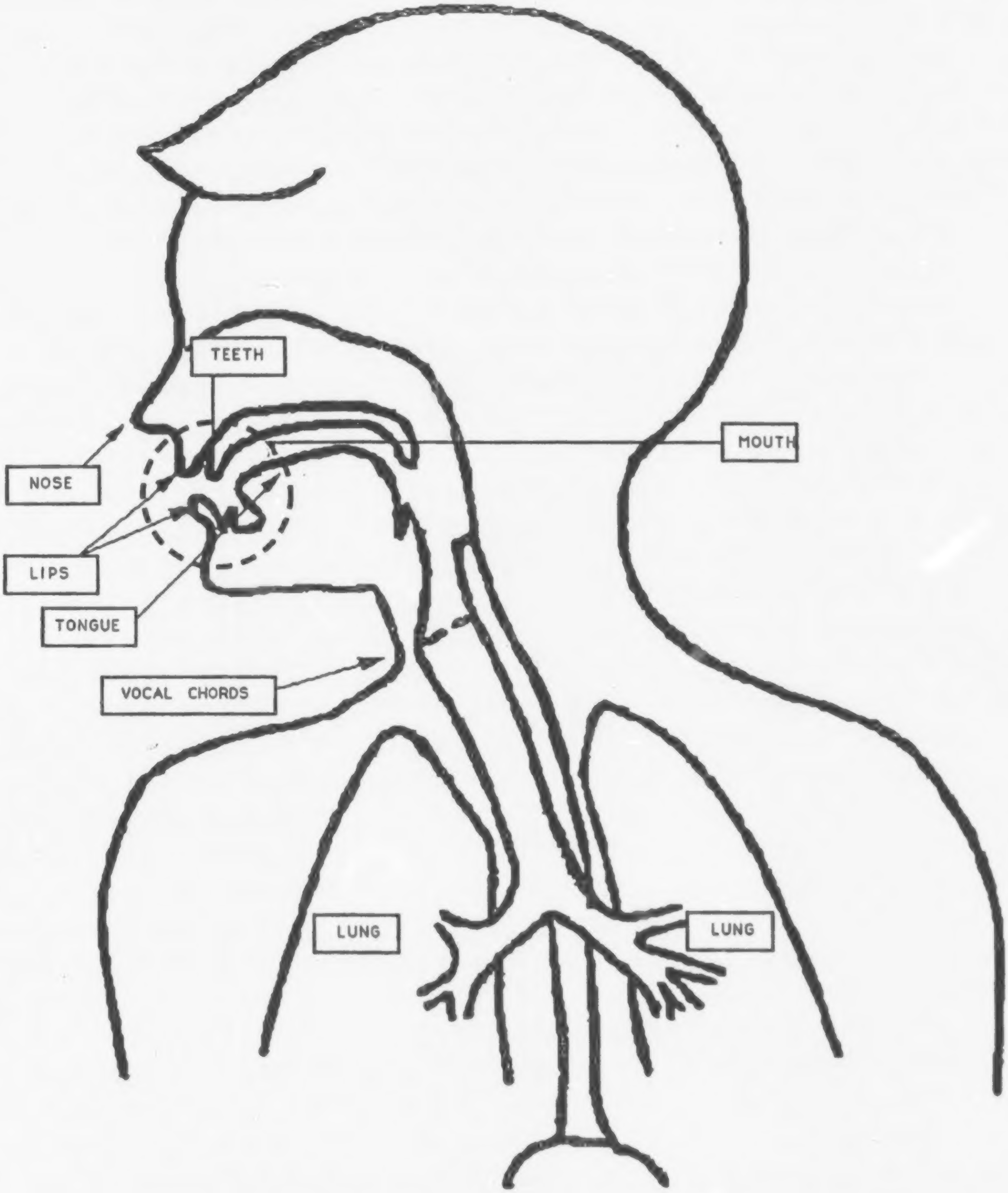
TEETH
MOUTH
NOSE
LIPS
TONGUE
VOCAL CHORDS
LUNG
LUNG

Module	Hour	Handout
2	1	4

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VOCABULARY DEVELOPMENT

12 Months	Two words besides "mama" and "dada"
14 Months	Three words besides "mama" and "dada"
16 Months	Five words in addition to "mama" and "dada"
18 Months	Ten "real" words
24 Months	Minimum of 50 words
30 Months	Vocabulary of 450 words
36 Months	Vocabulary approximates 1000 words
42 Months	Vocabulary of 1200 words
48 Months	Vocabulary of 1500 words

SPEECH SOUND DEVELOPMENT

Age	**Consonants**
3	p, w, h, n, m, ng,
3.5	y (as in yellow)
4	k, b, d, g, r
4.5	s, sh (as in show), ch (as in church)
6	t, v, th (as in thick), l
7	z, th (as in mother), zh (as in treasure), j (as in jewel)
Even later	dg (as in fudge)

The acquisition for some sounds may vary by as much as three years.

*Adapted from norms established by Mildred Templin (Certain Language Skills in Children, Institute of Child Welfare Monograph 26, Minneapolis, MN: University of Minn. Press, 1957)

SENTENCE DEVELOPMENT

AGE 2	That cat. Jason eat. No want! Where car? Baby cry. Mommy here? Want it! Me hungry.
AGE 3	That cat. Jason eating. I no want it. Baby crying. Where car is? Mommy's here. I want it! I'm hungry.
AGE 4	That's a big cat. Jason is eating. I don't want it. The baby is crying. Where's my car? Is mommy here? I want the cupcake. I'm so hungry.

*Adapted from: Your Child's Speech and Language: Guidelines for Parents. By Mary M. Brooks & Deedra L. Engmann-Hartung. Pro-Ed Publications.

The Enterprise Zone-Preschool Inclusion Project

Health Care: Infection Control, Medication Administration and Seizure Management

9

Health Care: Infection Control, Medication Administration, and Seizure Management

Major Concepts and Content

This session will cover three important topics: infection control, medication administration and seizure management. We will specifically be talking about the role of the caregiver in dealing with these topics. These are important topics for all parents and caregivers to know in order to help keep their children healthy. Some of our young children who are at risk or who have special educational needs rely heavily upon their caregivers to ensure that their environments are healthy and safe.

Children in childcare settings are more likely to be exposed to contagious diseases. Therefore, it is crucial that caregivers understand the importance of implementing infection control procedures. Additionally, caregivers should be knowledgeable about the proper medication management methods since most children will eventually need treatment that requires medicine. As we include children with special needs in the care giving setting there may be an increase in the number of children with seizure disorders. Consequently, caregivers should be aware of the signs of seizures, the procedures to follow and how to treat and manage seizures.

Materials

- ✓ FDA approved gloves
- ✓ Disposable diapers
- ✓ A large doll on which to practice diapering
- ✓ Soap
- ✓ Paper towels
- ✓ Table paper to cover diapering area
- ✓ Kitchen teaspoon
- ✓ Sink with running water - if this is not available instructor may want to bring in toy sink or set of water faucets to assist with role-play.
- ✓ Optional instructor made name/medication cards and schedule for review of medication administration activity
- ✓ Sample pill - powdered candy tablet
- ✓ Apothecary cup or other tool for crushing tablet
- ✓ Juice
- ✓ Water in clear plastic cups or bowls
- ✓ Tube of bottle of ointment -first aid cream, toothpaste, hand lotion
- ✓ Cotton swabs
- ✓ Bottle with pharmacy label

- ✓ Medication measuring spoon
- ✓ Medication syringe with no needle
- ✓ Medicine dropper for oral medicine
- ✓ Video on Universal Precautions
- ✓ Video: Seizures: An Overview
- ✓ VCR and Monitor
- ✓ The following handouts from the Mitch Modules:
  - ☐ Definition of Terms
  - ☐ How Diseases are Spread
  - ☐ How to Stop the Spread of Germs
  - ☐ Immunization Schedule
  - ☐ Hand washing
  - ☐ Diapering
  - ☐ Toileting
  - ☐ Universal Precautions
  - ☐ Examples of Medicines That May Need to Be Given in Caregiving Setting
  - ☐ Ways Medicines are Given
  - ☐ Medication Administration Authorization for Prescribed and Non-Prescribed Medication
  - ☐ Medication Log
  - ☐ Convulsive Seizures & Non convulsive seizures
  - ☐ Seizures

- What to Do if a Child Has a Seizure
- Seizure Record

Teaching Strategies

I. **Introduction** – (5 minutes) Presenter reviews the objectives for the session, explains content of handouts and expectations from participants.

II. **Discussion on Infection Control** (10 minutes)

How diseases are spread - Diseases that can spread are contagious, this means that the disease is catching; one-person can give it to another person. Germs cause diseases that are contagious. Germs are so small that they cannot be seen with the bare eyes. Bacteria, virus and fungus are types of germs. These germs can be found:

- In the respiratory tract causing illnesses such as the common cold or tuberculosis. Both of these diseases are known to spread by sneezing and coughing (airborne infection).
- In the intestinal tract, caused by eating foods that are contaminated with feces or food that has not been properly cooked or prepared; this can cause hepatitis or diarrhea.
- By direct contact from skin that is infected such as in cases of chicken pox or ringworm

- From insect bites such as mosquitoes causing meningitis or from bugs such as head lice.

How can the spread of diseases be stopped? – There are many effective methods that can be implemented in the care giving setting to help control infection. These are:

- Keeping children who are sick at home or isolated
- Practicing proper hand washing routines
- Maintaining the toilet and bathroom area
- Teaching children how to use a tissue, to dispose of it properly and then to always wash hands afterward.
- Teaching children to always wash their hands before eating and after using the bathroom.
- Proper food preparation, washing hands before preparation, keeping all surface areas for food preparation clean, and keeping foods covered
- Keeping the toys and play areas clean.
- Keeping pests under control by having regular fumigation services (request the use of pesticides that are safe for children)

III. **Video Hand washing and Diapering** (7-10 minutes) - This video provides information on the spread and prevention of diseases, hand-washing technique and universal precautions. The Center for Disease Control (CDC) has established guidelines called universal precautions. Universal precautions apply to everyone receiving care whether or not that person is known to have an infection. The use of gloves is stressed when having contact with blood, body fluids, vaginal secretions and semen. A brief discussion of AIDS and cytomegalovirus is presented.

IV. **Diapering, Hand Washing and Gloves Activity (10 minutes)** - Review the procedure to reduce the risk of spreading infection when diapering. Presenter demonstrates the proper technique for putting on gloves, removing gloves and discarding gloves after use. Demonstrate how to dispose of diapers and care for the diaper table. Have participants volunteer to role-play the diapering procedures.

Demonstrate to participants the correct hand washing technique, if there is access to running water. If not, pantomime can be used. Verbalize each step on the handout as it is being demonstrated. Ask participants to form smaller groups of three to four people. Have each group member practice pantomiming each step of the hand washing technique one at a time, while the rest of the group watches. Ask group members to help each other perform each step correctly.

V. **Discussion on Medication Administration (10 minutes)** – Presenter leads a discussion on the common medications given in a care giving setting, the need for medication administration in these settings, and the things that should be done to avoid mistakes when giving medications.

Medicines have to be given at prescribed times to work properly.

Therefore, it may be impossible to wait until the child is at home. Giving medication is a big responsibility and must only be done by someone who has been trained by a physician, a registered nurse or a pharmacist. In the care giving setting parental permission and a written physicians order is required before medication is administered.

Common medications that need to be administered in care giving settings include antibiotics such as Amoxicillin and seizure medication like Dilantin (See handout). Medications come in a pill or liquid. Liquid medication can be measured with a special medicine spoon or with a syringe for proper measurement. If a child is unable to chew or has difficulty swallowing, the pill should be crushed and mixed with something the child can safely swallow. However, some pills are time released and should not be crushed. It is important to give medications slowly and carefully to babies and children because they can choke easily. When giving eardrops, pull the ear back and up. When giving eye drops instill the drops in the lower part of the eye, do not drop on the eyeball. When giving nose drops, keep the child's head elevated or slightly raised to avoid having the child swallow medicine. For the ear, nose, and eyes, it is important that the dropper does not touch the skin.

All medication should be kept in a locked cabinet out of the reach of children. Medication that needs to be refrigerated should be kept in a refrigerator with a lock or in a locked box in the refrigerator. It is important to know the side effects of all medications that are given. If a medication is given in error, do not panic, call the poison control number and follow their advice. Also call the parent and physician and remain with the child.

VI. Measuring Demonstration Activity (5 minutes) – Stress that medication should never be given in a regular teaspoon since it is not accurate enough. Proceed to demonstrate measuring a liquid with the medication spoon and then with a syringe. Use water or juice in clear containers as medicine for demonstration. If water is used, it may be easier to see if it is slightly colored with food coloring. Show how to draw 2 c.c. of liquid into a syringe. Continue to demonstrate the use of a dropper. Enforce the need to read medicine labels carefully so that drops for the ears and eyes won't be confused with regular medicine.

VII. Break (10 minutes)

VIII. Medication Administration Scenario (10 minutes) - Have participants break into small groups and identify a reporter for each group. Give each group a copy of the scenario and the Medication Administration Checklist (handouts). Ask them to make a list of points they need to consider to simplify the medication administration schedule in their classroom, and develop a plan that addresses the points on the Medication Administration Checklist.

Scenario: Sally Jones comes to the childcare center at 8:00 a.m. and stays until 6:30 p.m. Sally has a seizure disorder, which is controlled with medication, therefore Sally should get her medication on time (Phenobarbital, 4 c.c. three times a day). (2) Carlos also comes to the childcare center and has an ear infection for which he is being given amoxicillin (one teaspoon four times a day). Sally's mother wants her medication to be given at 9:00, while Carlos takes his amoxicillin at 8:30 and 2:30. As a teacher you want to reduce the number of times during the day that you must disrupt your schedule to administer medications. What things do you need to consider before setting up the medication administration schedule?

Ask the groups to come back to the large group and for the reporter to share the ideas on their lists. If they did not come up with all of the considerations you may give additional input. The following list details the points that should be considered:

- ✓ Ask the parent what time the medication is given at home and how is the medication administered (e.g. crushed with food, without food, in liquid form etc...)
- ✓ Ask the parent if it is okay to call the physician to see if it is okay to change the time of the medication
- ✓ Try to give as many medications as possible at the same time of day (e.g. Carlos and Sally would receive the first

dose of medication at 9:00 a.m. would then receive their second doses at 3:00 p.m.

IX. **Discussion on Seizure Disorders and Management (30 minutes)** – When including children with disabilities in the care giving settings it is more likely that there will be children with seizure disorders. Consequently, it is important that caregivers be knowledgeable about seizure disorders and management. In this section of the training participants will learn what seizures are, the common types of seizures, what to do when a child has a seizure, the importance of seizure medication, and who to call for help.

Presenter distributes handouts on types of seizures and shares the following information. Seizure is also known as epilepsy. It is a result of abnormal or unusual electrical discharges in the brain, causing abnormal behavior and body movements. There are many types of seizures varying from brief loss of attention to convulsions (shaking of the whole body) with loss of consciousness. Episodes of seizure occurrence are unpredictable and sometimes can be caused by other conditions such as very high fever. When a child with no previous history of seizure disorder experiences a seizure, a medical checkup is recommended.

Types of seizure

The type of seizure depends on which area of the brain has a malfunction and how much of the brain is affected.

- Generalized seizures are also known as Grand-mal seizures. They are characterized by convulsions with jerky movements and rigidity of the body. The convulsions may be precipitated by a cry/scream. The child may become unconscious, fall and be incontinent of bladder and bowel.
- Absence seizures are known also as Petit mal or non-convulsive seizures. There is usually a loss of awareness, rapid blinking of the eye or just a blank stare or repetitive hand movement. The child will return to the previous activity once the seizure has ended. Absence seizures are often mistaken for inattention or daydreaming.
- Simple partial or Jacksonian seizures are characterized by jerking movements of the toes and fingers. There is no loss of consciousness, but senses may be distorted with the child experiencing feelings that are not real.
- Complex partial seizures are also known as the psychomotor or temporal lobe seizures. They produce behavior that can be confused with drunkenness or drug intoxication. There is no loss of consciousness, behavior is confused and repetitive, and the child is unaware of his activity.

It is important that the childcare provider knows what to do when a seizure occurs. Most importantly, that person should remain calm. A child diagnosed with seizure disorder will be on prescribed medication to control the seizure. It Is important that the child's medication regime, be managed in the care giving setting the same way that is done at home; so consult with the child's parents to make sure. Children with seizure disorder should be treated the same as every other child. It is not necessary to restrict their activity. However, the other caregivers need to know if a child has a history of seizure disorder.

Using the handout "What to Do if a Child Has a Seizure" go over with participants the steps to follow when a seizure occurs. Most seizures last 2-3 minutes and do not require emergency intervention, however there are times, when emergency help is required such as:

- A new onset seizure (no previous history) could be the sign of some other serious illness.
- A seizure that last over 5 minutes
- A second seizure or difficulty breathing after a seizure, or slow recovery
- An Injury related to the seizure activity

Always notify the parent when a child has had a seizure. Have emergency phone numbers available of parents and physician. Keep a log of the seizure activity. Document the time of duration and describe what took place before during and after the seizure. A well informed caregiver can keep a child safe and also help that child make the most of his potential.

Conclude the discussion session by asking participants to share their personal experiences with children or adults with seizure disorders.

The presenter can also share his or her personal experiences.

X. Video on Seizures (10 minutes) – View video with participants. This video shows the different types of seizures and the respective caregiver's response to when seizures occur.

XI. Conclusion and Evaluation (10 minutes) – The presenter reviews the major points and answer questions. When there are no more questions, hand out the evaluations. While participants are filling out the evaluation write the date, time, location and topic of the next training session where everyone can see it. Read aloud the information and collect the evaluation.

References

Comprehensive Epilepsy Center of Miami Children's Hospital . *Seizures: An Overview* [Video]. Miami, FL. (Available from Comprehensive Epilepsy Center, Miami Children's Hospital, 61225 SW 31st Street, Miami, FL 33155, Attention Pat Dean; phone (305) 666-6511, ext. 2608.)

National Center for Infectious Diseases (1994). *The ABC's of Safe and Healthy Child-care Hand washing and Diapering* [Video]. Child Care Health and Safety Program Centers for Disease Control and Prevention,, 1600 Clifton Road, Atlanta, Georgia 30333. (Available from Public Health Foundation at 1-877-252-1200.)

Tetlow, P. (1990). Health Care: Infection Control, Medication Administration, and Seizure Management. "In C. F. Abbott & D. M. Fernandez (Eds.), *Mitch Module 8, Model of Interdisciplinary Training for Children with Handicaps: A Series for Caregivers of Infants and Toddlers*. Florida Department of Education. Division of Public Schools. Bureau of Education for Exceptional Students.

Definition of Terms

- **AIDS**: The letters AIDS stand for Acquired Immunodeficiency Syndrome. AIDS affects a part of the body's immune system and makes it difficult for the body to fight infection. The virus infects and destroys special white blood cells called "T-Helper Cells".

- **Alert**: This refers to being awake and aware of what is happening.

- **Apothecary Cup**: This is a cup with a special device for crushing pills. This particular cup is used by pharmacists. However, other containers can be used to crush pills.

- **Center for Disease Control (sometimes called CDC)**: CDC is a place in Atlanta, Georgia, where scientists study diseases. They have recently published guidelines for dealing with AIDS.

- **Contagious**: Refers to a disease that can be given to another person by contact.

- **Germs**: A germ is a very, very small organism. Usually "germ" refers to an organism that can make you sick.

- **Immunizations**: These are shots or special liquids given to children to protect them against certain diseases.

- **Intestinal Tract or the Digestive System:** This tract has to do with eating and elimination. It begins with the oral cavity and includes the organs involved in digesting food. It includes the small and large intestines where bacteria or parasites are often found.

- **Respiratory Tract**: The respiratory system has to do with breathing. In man it includes the nasal cavity, epiglottis, pharynx, larynx, esophagus, trachea, bronchi, and lungs. Bacteria found in this system can be expelled into the air through the nose or mouth.

- **Restrain**: To hold or confine a child in such a way that is not harmful to the child.

Module	Hour	Handout
8	1	1

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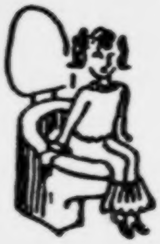
How Diseases are Spread

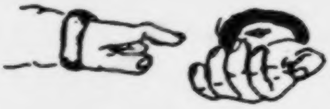
Diseases are spread by germs.

Germs are spread in several ways:

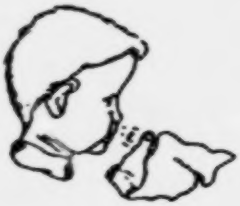
- Intestinal tract (stool)



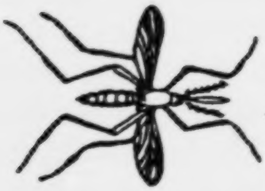
- Direct contact



- Respiratory tract (coughs, sneezes, runny nose)



- Insects.



Module	Hour	Handout
8	1	2

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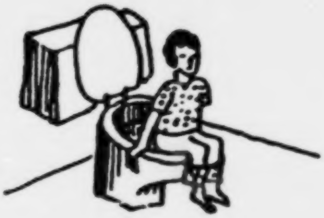
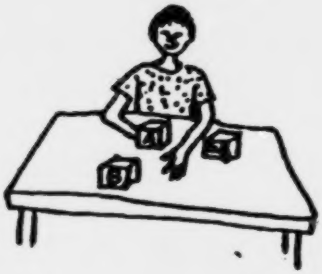
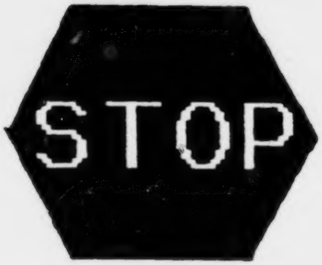
How to Stop the Spread of Germs

Intestinal Spread:







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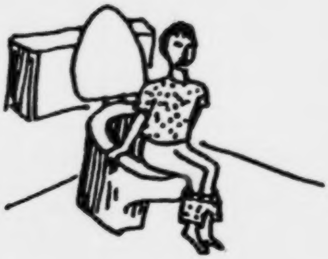

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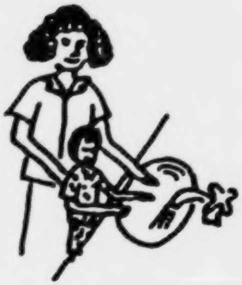

Module	Hour	Handout
8	1	3

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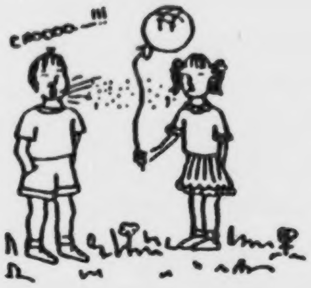
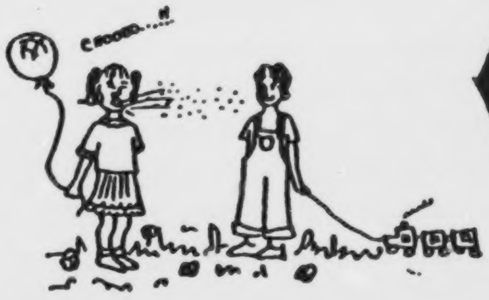
How to Stop the Spread of Germs (con't.)

Respiratory Spread:





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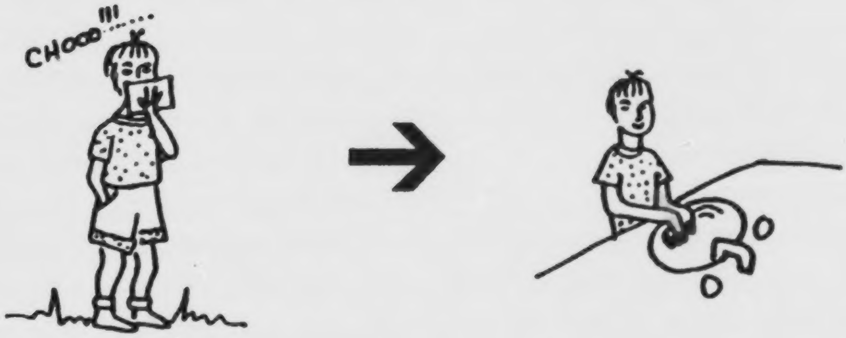

Module	Hour	Handout
8	1	3 (con't.)

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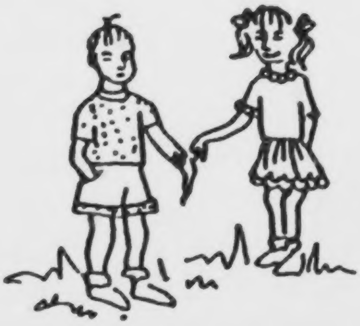
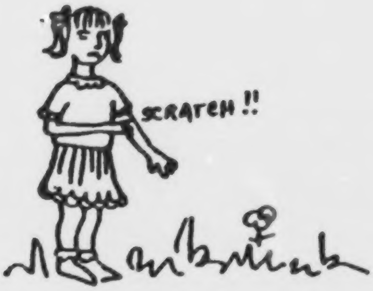
How to Stop the Spread of Germs (con't.)

Direct Contact





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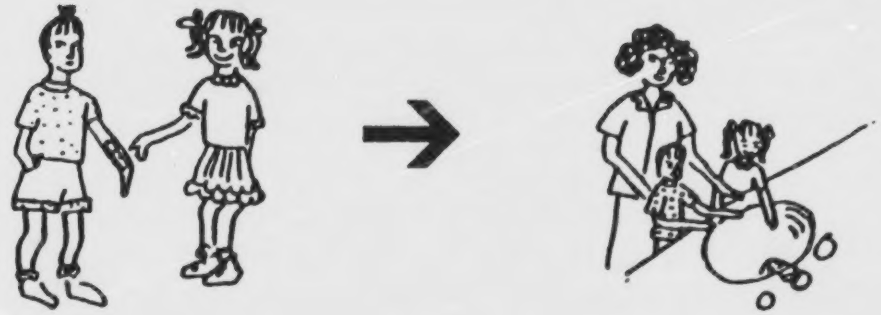

Module	Hour	Handout
8	1	3 (con't.)

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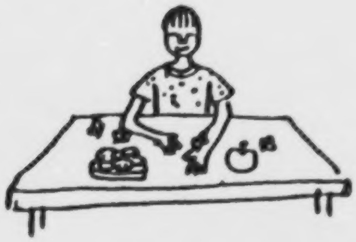
How to Stop the Spread of Germs (con't.)

Insects and Animal Contact:



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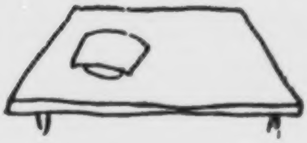

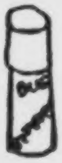

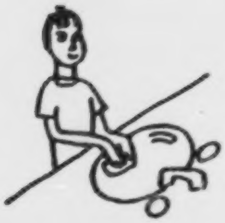

Module	Hour	Handout
8	1	3 (con't.)

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Immunization Schedule

Recommended Schedule For Healthy Children

2 months	DPT & OPV
4 months	DPT & OPV
6 months	DPT
1 year	TB Test
15 months	MMR
18 months	DPT & OPV booster
4-6 years	DPT & OPV booster
14-16 years	Td

DPT - Diptheria, Tetanus, Pertussis

OPV - Oral Polio Vaccine (trivalent)

MMR - Measles, Mumps, Rubella

Td - Tetanus, Diptheria (no Pertussis)

The HIB vaccine is recommended, but not required. This vaccine protects children from a certain form of meningitis. It is given between 18 and 23 months of ages.

Module	Hour	Handout
8	1	4

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Handwashing

- Remove jewelry - when possible, avoid wearing jewelry when working with children.
- Use soap and running water.
- Rub hands vigorously as you wash them.
- Wash back of hands, palms, wrists, between fingers, and under finger nails.
- Rinse your hands well and leave the water running.
- Dry your hands with a single use towel.
- Turn off the water by using a paper towel, not your bare hands.
- Remember to wash the child's hands also using the above procedure.

Module	Hour	Handout
8	1	5

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Diapering

- Have supplies ready including clean diaper, any needed clothing, and towelettes.
- Place fresh paper on the changing table. It is important to change the paper after each diaper change.
- Hold the child away from your body when you pick him up.
- Place child on changing table.
- Put on gloves.
- Remove soiled diaper.
- Place soiled diaper in a plastic lined container.
- Clean child with a towelette, wiping front to back.
- Remove table paper and put it in a plastic lined container.
- Discard gloves. Be careful to touch only the uncontaminated side of the gloves.
- Place clean paper on the table.
- Diaper and dress the child.
- Wash the child's hands.
- Return child to a safe area.
- Remove table paper and discard it touching only the uncontaminated side of the paper.
- Wash your hands.
- Clean and disinfect the diaper changing area including the sink if it was used.
- Wash your hands.

Module	Hour	Handout
8	1	6

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Toileting

- Place dirty clothing in a bag for parents to take home. Do not wash at school.
- Help the child use the toilet. (If child-sized toilets are not available, seats that adapt an adult toilet are better than potty chairs for controlling disease spread.)
- Help the child wash hands using proper handwashing technique.
- If a potty chair is used, empty it. Do not rinse in sink used for handwashing.
- Wash your hands.
- At the end of each day, clean and disinfect the toilet, adapted toilet seats and/or potty chairs.

Module	Hour	Handout
8	1	7

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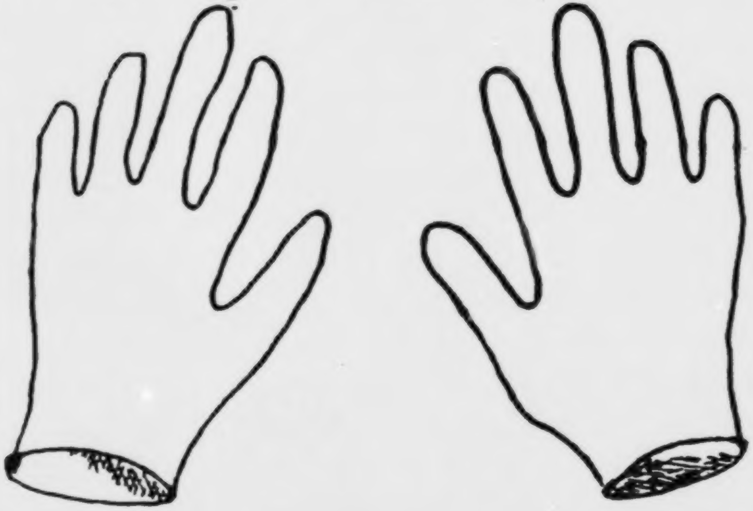
Universal Precautions

WEAR FDA APPROVED LATEX GLOVES WHEN:

- in contact with any blood or fluids containing blood
- in contact with semen or vaginal secretions.

KEEP GLOVES

- handy at all times
- in any area where there are children, including the playground
- around diapering and toileting areas.



Module	Hour	Handout
8	1	8

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Examples of Medicines That May Need To Be Given In Caregiving Setting

Note: Medicines should be given ONLY with written permission from the parent and the child's physician. This procedure should be followed or both prescribed and non-prescribed (over-the-counter) medication.

ANTIBIOTICS

Reason for use - to fight infections such as those of the ear or throat

Examples:
- **Amoxicillin**
- **Ampicillin**
- **Cloxicillin**
- **Ceclor**

ANTICONVULSANTS

Reason for use - to control seizures

Examples:
- **Phenobarbital**
- **Clonipin**
- **Dilantin**

ANTIPYRETIC

Reason for use - to control fever

Examples:
- **Tylenol**
- **Tempra**
- **Liquiprin**
- **Panadol**

Module	Hour	Handout
8	2	1

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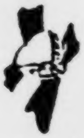
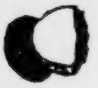
Ways Medicines Are Given

- Tablets



1/4 tablet



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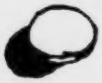
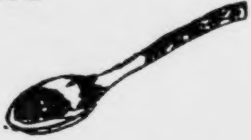
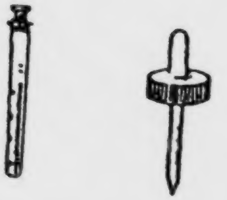


1 tablet

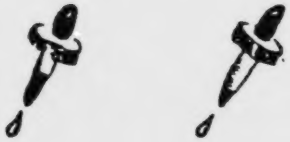
broken or crushed



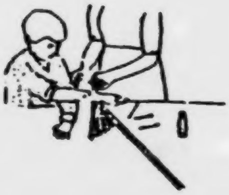
- Liquids



- Drops (Keep tips of droppers sterile. Keep child lying down for ear drops. Keep child's head raised for nose drops.)



- Ointments, Creams, Lotions



Module	Hour	Handout
8	2	2

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Sample

Medication Administration Authorization for Prescribed and Non-Prescribed (Over-the-Counter) Medication

Child's Name **Date of Birth**

Medications can only be administered at school when failure to receive such medication could jeopardize a child's health. The Physician Authorization and Legal Guardian Permission segments of this form must be completed and signed prior to execution of the prescription.

Physician's Authorization (To be completed by the prescribing physician.)

The above named child is under my medical supervision. I have prescribed the following medication:

Reason(s) for medication:

Date to begin: Date to end

Possible adverse reactions of the medication:

What to do if a dose is missed:

Special instructions:

Physician's Name: Physician's Telephone:

Physician's Address:

Physician's Signature: Date:

Legal Guardian Permission (To be completed by child's legal guardian.)

Name Home Telephone:

Address:

Business Telephone: Emergency Telephone:

I hereby request that my child be given the above medication while in school and away from school for activities. I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication where the person administering such medication acts as an ordinarily reasonably prudent person would have under the same or similar circumstances. I understand that I must notify the school of any changes in my child's medication. I understand that I am responsible for ensuring that the medication arrives safely at school and for refilling the medication prescription as needed.

Signature of Legal Guardian: **Date:**

Module	Hour	Handout
8	2	4

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Medication Log

(Sample)

Name of child: ______________________

Address: ______________________

Telephone (Home and Contact): ______________________

Record of Administration

Medication	Dose	Date/Time	Signature of Person Administering	Comments

Module	Hour	Handout
8	2	7

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Convulsive Seizures - Children Lose Consciousness

SEIZURE TYPE	ALSO CALLED	DESCRIPTION	FIRST AID
Generalized Tonic-Clonic	**Grand Mal Fits, Spells, Attacks**	**Two-Stage - Tonic & Clonic** **Tonic stage progression:** • cry • fall • stiffness • muscle jerks • heavy irregular breathing • loss of consciousness • stiffening of body • drooling • pale skin • occasional loss of bowel/bladder control. **Clonic stage:** • alternating rigidity and relaxation of muscles • period of drowsiness, disorientation, and fatigue.	Note time seizure starts. Make environment safe. Do not put anything in mouth. Do not restrain. Do not hold tongue. Keep head to one side. Don't give liquid. Call for emergency help if: one seizure lasts over 5 minutes, or multiple seizures occur. Start CPR if breathing is absent. Report to parents. Record seizure activity and share with doctor as indicated.

Module	Hour	Handout
8	3	1

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*MITCH: Model of Interdisciplinary Training for Children with [illegible]

Non-Convulsive Seizures

SEIZURE TYPE	ALSO CALLED	DESCRIPTION	FIRST AID
Absence	Petit Mal	Blank stare for a few seconds. Some may have chewing movements. Often mistaken for daydreaming. Unaware during seizure.	Do not try to grab or restrain child. Gently guide child to safety. Some children may wear a helmet for head protection.
Simple Partial	Jacksonian	Child awake and aware. Uncontrollable jerking. Starts in fingers and toes and spreads up body. Can progress to convulsive seizure.	No first aid is necessary unless seizure progresses to a convulsive seizure; then follow the first aid measures under convulsive seizures.
Simple Partial	Sensory	May see or hear things that are not there. May feel unexplained emotions.	Write down exactly what you observed.
Complex Partial	Psychomotor or Temporal Lobe	Starts with blank stare, followed by chewing then random activity such as picking at clothes, walking away.	Report to the parents. If this is the first time the child has ever had a seizure, tell the parents that the child must go to the doctor. The child needs to be seen by a doctor even though he may appear to be fine.
Atonic	Drop Attacks	Child suddenly falls. After 10 seconds he can walk again.	
Myoclonic		Sudden brief muscle jerks that involve one body part or whole body.	No first aid. Recommend medical evaluation.
Infantile Spasms		Usually in child 3 months to two years of age. Head falls forward. Arms/knees flex.	No first aid. Recommend medical evaluation.

Module	Hour	Handout
8	3	1 (con't.)

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SEIZURES

WHEN TO CALL FOR EMERGENCY HELP

- When one seizure lasts over 5 minutes.
- When several seizures occur in a row with no break in between.
- When child has been seriously injured.
- Whenever you need to start Cardiopulmonary Resuscitation.

  CPR should be started whenever breathing is absent.

- Emergency number: ______________

Module	Hour	Handout
8	3	2

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What to Do if a Child Has a Seizure

Determine if the child is having a seizure.

Remain calm.

Note beginning and ending time of seizure.

Protect the child from injury. If the child is standing or sitting, gently lower him into a lying position. Clear the area of objects.

Do not try to restrain the child.

Do not insert anything in the child's mouth.

Do not offer food or drink until the child is fully awake.

Stay with the child until he is fully alert and awake.

Call for emergency help when:

- The child has one seizure immediately after another with no time in between.
- The seizure lasts longer than 5 minutes.
- The child has been injured seriously.
- The child does not start breathing after a seizure. Begin mouth-to-mouth resuscitation and call for help.

AFTER THE SEIZURE

Stay with the child until child is fully alert.

Allow the child time to rest.

Reassure the child and provide child with information about what just happened, as appropriate to child's age and developmental level.

Reassure the other children in the caregiving setting.

Write down what you observed.

Report the seizure to the child's parents.

Note whether any changes were made in medication after the seizure.

Module	Hour	Handout
8	3	3

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SEIZURE RECORD

Name ______________ Age ________ Diagnosis ______________________ Medication __________

Dosage and administration times: ____

DATE	BEHAVIOR BEFORE SEIZURE	BEGINNING TIME	DESCRIPTION OF SEIZURE	ENDING TIME	INTERVENTION NEEDED	CHILD'S REACTION AFTER SEIZURE	WHO WAS CONTACTED

Module	Hour	Handout
8	3	4

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TYPES OF MEDICATION ERRORS

WRONG CHILD

WRONG MEDICINE

WRONG DOSE

WRONG ROUTE

WRONG TIME

ANY COMBINATION OF THE ABOVE

Medication Administration Checklist

- ✓ Obtain the central log book
- ✓ Check the doctor's order with the central log for child's medication
- ✓ Check three times to avoid errors
- ✓ Check the parental permission form for signature and name of the medication
- ✓ Get the medication from its locked area
- ✓ Check the original pharmacy label on the bottle with the doctor's order three times
- ✓ Check individual log for the last time medication was given .
- ✓ Measure the medication carefully
- ✓ Check the child's name
- ✓ Give the medication
- ✓ Chart the medication on the individual medication form
- ✓ Return the medication to the locked area.
- ✓ Check central log for the next time the medication is to be given

The Enterprise Zone-Preschool Inclusion Project

Working Together: Communication and Teamwork in the Caregiving Setting

10

Working Together: Communication and Teamwork in the Caregiving Setting

Major Concepts and Content

It is common knowledge that effective communication skills are essential for success. Consequently, effective communication skills are necessary for the successful implementation of an inclusionary program. During this session we will explore communication between caregivers, including parents, early childhood educators; child care workers and other professionals. It is important that all of us who work with children understand each other. All too often we hear that parents, families or other caregivers did not understand what educators or other professionals said about their children. Or we learn that administrators and other staff members do not understand what parents or care providers have to say. The purpose of this session will be to increase participants' knowledge about the nature of communication. It is important that participants gain an understanding of nonverbal communication, listening skills and the roadblocks to communication. It is also helpful to learn about assertive communication techniques in order to improve the ability to communicate effectively. Furthermore, to be able to work successfully towards common goals it is essential to become familiar with the steps in problem solving, learn how to give praise, and work effectively in teams.

Communication is the process of sharing ideas, information, thoughts, feelings, and opinions. This is done not only through words, but also through verbal means such as body language. Body language includes gestures, facial expressions and postures (Abbott, C. F. & Greenwood, C., 1999).

To promote maximum learning in this session the presenter modeled and implemented effective communication skills. During the activities and discussion the presenter highlighted communication techniques employed by the different participants.

Materials:

✓ The following handouts from the Mitch Modules:

- Communication
- Assertive Communication
- Roadblocks to Communication
- How to Give Praise
- Factors that Can Influence Stress in Adults
- Common Responses of Parents with Special Needs Children

- ✓ Attitude Bear Activity handout
- ✓ "Attitude" poem
- ✓ "Conferring with Parents when you're concerned that their child needs special services," article (See reference for information on obtaining a copy)
- ✓ Flip chart/dry erase board/chalkboard
- ✓ Markers or chalk

Teaching Strategies

I. **Introduction** (10 minutes) - Presenter reviews the fundamentals of communication using the communication handouts and tells participants that they will learn some new ways in which to work more effectively with one another. When the avenue of communication is open and honest among co-workers, optimal production can be achieved. It is vital to have an open and corresponding communication with colleagues and parents. Childcare providers should strive to establish rapport with the parents. With the lines of communication open, problems can be promptly addressed, and appropriate action can be taken in compliance with the wishes of both the parents and teachers.

II. **Roadblocks to Communication** (20 minutes) – Use the Roadblocks to Communication handout to facilitate the following discussion. Inform participants that communication is essential among people in order to share ideas and opinions. People communicate through different ways including direct speech, writing, and body language. Identify and discuss with participants the roadblocks of effective communication. Compare these roadblocks with more appropriate and assertive methods of communication, such as maintaining eye contact and listening to one another. Highlight that people tend to become very defensive when someone approaches them with criticism or sarcasm. Advise participants to avoid conversation that is hostile and judgmental. Communication is more effective when the parties involved maintain an open mind, are sensitive, and respectful.

III. **Activity** (20 minutes) **Bear Partners** – Participants are given a black/white picture of a teddy bear and are instructed to pass the picture on to the person sitting next to them. That person then writes positive things about the person that gave them the picture, on the outside of the bear, such as friendly, strong, compassionate, or loving. The bear is then passed back to its original owner, and they read the comments aloud. The presenter then instructs the participants to write positive things about themselves on the inside of the bear. This activity invokes positive self-esteem and viewing one's strengths through the eyes of a colleague.

IV. **Break** (10 minutes)

V. **Discussion on Parents and Stress** (20 minutes) - Participants are reminded that certain stressors may lessen their patience, thus affecting their ability to properly care for their children. Each person responds to stress differently, therefore discuss major factors that are known to enhance stress. For example, severity of a child's disability, or lack of support from co-workers and family, may become very stressful. Furthermore, parents may respond differently when they learn of their child's disability. Some may feel shock and disbelief; others may experience an overwhelming sense of resentment, while others may fall into a deep depression. It is important for the caregiver to recognize that parents may be in different stages of acceptance regarding their child's disability and to provide understanding and support. The caregiver can help parents recognize that their feelings are normal, but at the same time highlight the child's strengths. If a caregiver does not feel comfortable in doing so, they can always opt to redirect the parents to support groups and local resources.

VI. **Appropriate Methods of Praise** (5 minutes) – Discuss the appropriate methods of praising. Inform participants of the benefits of learning how to give praise in an appropriate and sincere manner. Praise should be given to the actual act and the person's character. For example, a child should be praised for coloring a beautiful rainbow, not complimented on how creative they are. Furthermore, praise should be both creative and descriptive, and directed towards the individual, such as "look at the colorful rainbow that Devon drew, doesn't it brighten up the sky." Ask participants to practice praising one another's teaching skills in an effective manner.

VII. **Assertive Communication Role Play** (15 minutes)- Distribute the handouts on Assertive Communication. Use the handouts to lead a discussion on how to be assertive without being aggressive or offensive. Ask participants to find a partner who they will practice assertive communication with. Read aloud the following scenario and ask them to choose whether they will be the parent or the caregiver. Say "You are the parent of a child with a disability. Your child has Down syndrome and has chronic upper respiratory infections. However, while he has these infections they are not contagious. He is often congested and has mucus in his nose. When you come to pick him up from school his caregiver tells you that he is sick with a cold and needs to be seen by a doctor before he can come back to school." Ask the participants to use the skills they have learned regarding effective communication and assertiveness to role-play this situation.

VIII. **Conclusion and Evaluation** (5 minutes) –Hand out evaluations. While participants complete the evaluation write the date, time, location, and topic of the next training session. Read the information aloud and collect the evaluations.

References

Abbott, C. F. & Gold, S. (1991). Conferring With Parents When You're Concerned That Their Child Needs Special Services. *Young Children*, 46 (4), 10-14.

Abbott, C. F. & Greenwood, C. (1999). Working Together: Communication Skills for Families, Early Childhood Educators, and Other Professionals. *Grow to Five Series, Module B*. Clearinghouse Information Center, Bureau of Instructional Support and Community Services, Division of Public Schools and Community Education, Florida Department of Education, Room 614 Turlington Bldg., Tallahassee, Florida 32399-0400; phone 850-488-1879; e-mail: cicbiscs@mail.doe.state.fl.us.

Cuenca, E. & Saenz, A. (1990). Working Together: Communication Skills for Parents, Caregivers, and Other Professionals. "In C. F. Abbott & D. M. Fernandez (Eds.), *Mitch Module 1, Model of Interdisciplinary Training for Children with Handicaps: A Series for Caregivers of Infants and Toddlers*. Florida Department of Education. Division of Public Schools. Bureau of Education for Exceptional Students.

Communication

Sharing Ideas, Information,

Thoughts, Feelings, and

Opinions by Verbal Means Such

As Speech and Writing and by

Nonverbal Means

Such As Body Language and

Tone of Voice

B–1–1

Assertive Communication— *What* We Say

- Show you know how others feel.
- Offer choices.
- Use "I" language.
- Avoid accusing or blaming.
- If you ramble, stop.
- Ask for time if you need it.
- Be a "broken record."
- Accept yourself.

B–2–2

Assertive Communication—*How* We Say It

- Maintain eye contact.
- Maintain good posture.
- Maintain an appropriate facial expression.
- Use an even, well-modulated voice.
- Use good timing.
- Listen to the other person.

B–2–1

COMMUNICATION

COMMUNICATION
the process of

sharing ideas *thoughts* *opinions*

among people

By means of:

gesture *speech* *writing, and/or*

*body language**

---

*A combination of posture, movement and facial expression.

Module	Hour	Handout
11	1	1

*MITCH: Model of Interdisciplinary Training for Children with Handicaps: Florida Diagnostic and Learning Resources System/South, FDLRS/South, Exceptional Student Education, Dade County Public Schools, 9220 S.W. 52nd Terrace, Miami, FL 33165; (305)274-3501.

MITCH*

ASSERTIVE COMMUNICATION

Assertive Communication:

- Maintain eye contact.
- Maintain good body posture.
- Maintain an appropriate facial expression.
- Use an even, well modulated voice.
- Utilize good timing.
- Listen to the other person.

ROADBLOCKS TO COMMUNICATION

ORDERING

WARNING/THREATENING

JUDGING/CRITICIZING/BLAMING

NAME-CALLING

SARCASM

DIVERTING

UNSYMPATHETIC

Module	Hour	Handout
11	1	5

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*MITCH: Model of Interdisciplinary Training for Children with Handicaps

How To Give Praise

- Praise the act, not the person's character.
- Avoid praising expected behavior.
- Recognize a person's feelings.
- Identify what is being praised.
- Be creative and descriptive.
- Personalize praise.

Adapted from Ginot (1972).

Module	Hour	Overhead/ Handout
11	3	10

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Factors that Can Influence Stress in Adults

Temperament and/or behavioral characteristics of the child.

Caregiving demands.

Severity of handicap(s).

Family's level of psychological functioning.

Economic resources.

Support available from family/community/professionals.

Programs available for child and family.

Module	Hour	Handout
4	2	1

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Common Responses of Parents With Special Needs Children

Common Responses	Parents' Feelings/Actions	What Caregivers Can Do
Shock Disbelief Denial	Denial of handicap. Pretend handicap is not there. Excuses for why child is having "trouble." Shame, guilt, unworthiness. Overcompensate by intense training. Doctor "hopping" - visits to different doctors to find out what the parent wants to hear.	Listen with acceptance. Assure that feelings are normal. Focus on working together with the child. Affirm child's strengths. Direct parents to sources of information, gently.
Anger Resentment	May become angry at seemingly insignificant things. Sound envious of others. Verbally abusive to teachers or others that have taught or been part of the child's diagnosis. May take statements by professionals or others out of context and restate them to the child's advantage.	Listen with acceptance. There is no need to agree or give suggestions. Direct parents to sources of information. Affirm your acceptance of the child and focus on working together. Avoid giving examples of what others have done.
Bargaining	Work hard with the child, i.e. "If I work with him every day he will catch up." Postponing acceptance of the child's handicap; i.e., "This is just a stage." "His eyes are crossed - when that's corrected he'll catch up."	Listen with acceptance. Show caring for child and for the parents.
Depression Discouragement	May be more open to suggestions for helping the child. Mourn the loss of the image of "normal child." Have a sense of helplessness and hoplessness.	Listen with acceptance. Avoid criticism or too much praise. May need to suggest support group, counseling, or other local resources.
Acceptance Adjustment	Realize something positive can be done. Accept the whole child. Adjust lifestyle. Recognize needs of child. Learn new techniques.	Teach new training techniques. Praise progress. Encourage realistic expectations.

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Module	Hour	Handout
4	2	2

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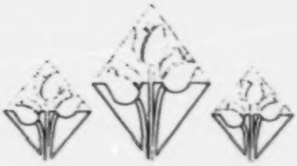
ATTITUDE

by

Charles Swindoll

"The longer I live, the more I realize the impact of attitude on life. Attitude, to me, is more important than facts. It is more important than the past, than education, than money, than circumstances, than failures, than successes, than what other people think or say or do. It is more important than appearance, giftedness or skill. It will make or break a company . . a church . . a home. The remarkable thing is we have a choice every day regarding the attitude we will embrace for that day. We cannot change our past . . we cannot change the fact that people will act in a certain way. We cannot change the inevitable. The only thing we can do is play on the one string we have, and that is our attitude . . I am convinced that life is 10% what happens to me and 90% how I react to it."

STRENGTHS



The Enterprise Zone-Preschool Inclusion Project

Professionalism and Advocacy

11

Professionalism and Advocacy

Major Concepts and Content

This session focuses on the profession of early childhood educators. The participants are presented with the concepts of being a professional and what constitutes a professional. It also focuses on the importance of community involvement. The participants are encouraged to register to vote and to encourage parents and other individuals to do the same. Participants are persuaded to meet and follow the activities of their local, state, and national representatives.

Materials

- ✓ Division of Early Childhood (DEC) of the Council for Exceptionall Children – Position of Inclusion
- ✓ Collaborative Partners (Handouts)
- ✓ Four sheets of flip chart paper for first Walk About Activity with the following headings:

    - What is the difference between a job and a profession?
    - What are some qualities of a professional?
    - Name some early childhood professional organizations.
    - What are some benefits of belonging to a professional organization?

- ✓ Three sheets of flip chart paper for second Walk About Activity with the following headings:
    - My favorite activity from all the sessions was…
    - One thing I have learned about inclusion is…
    - I would like to know more about…
    - Have the names of all the sessions listed on this paper

  Or have 11 sheets of flip chart paper headed with the titles of all the training sessions.
- ✓ Markers
- ✓ Video- The ABC's of Inclusion
- ✓ Membership Applications for NAEYC and CEC

Teaching Strategies

I. **Walkabout** (15 minutes) – Prior to the session the trainer should post the "Walkabout" questions on the walls around the training room. As participants come into the room ask them to walk around and answer the questions by writing their responses under the questions. When everyone has had an opportunity to respond, the trainer should either read the answers aloud, or ask the participants to read them to the group. The trainer can lead a discussion regarding professionalism and distribute handouts and membership applications.

II. **Administrative Concerns** (10 minutes) – Dedicate this time to addressing any concerns that the administrators may have.

III. **Activity** (5 minutes) – This is a very simple but powerful activity. The point of this activity is to highlight the importance of developing a relationship with local community politicians. Ask everyone in the audience who knows who the president of the United States is to stand up. Continue by asking who knows who their U.S. Senator is, those who do not know should sit down. Ask those who are standing, up if they know who their state senator is. Those who do not know should sit down. Now ask who knows who their state representative is. Finally ask participants that they remain standing only if one of their local representative knows who they are. Stress the importance of forming relationships with local representatives.

IV. **Lecture** (20 minutes) – Promote participation in community activities and child advocacy. Discuss local, state and national policies that affect early care and education. Go over the handouts.

V. **Re-Cap Video** (30 minutes) – ***ABC's of Inclusion.*** View the video with participants. Ask participants to write down one new idea or fact that they learned during the video. If time permits ask for volunteers to share their new idea with the rest of the group.

VI. **Break** (10 minutes)

VII. **Large Group Activity** (30 minutes) – **Walkabout.** During the break tape the flip chart paper to the walls with the following captions: "My favorite activity from all the sessions was…" " One thing I have learned about inclusion is …" " I would like to know more about…" Ask participants to take the markers with them and to write or draw as many responses as they like on the papers. Display one paper with the names of all the sessions on them to spark their memories. Review by asking for volunteers to read from the posters when they are completed. Allow time for discussion as the participants remember the sessions and the activities. As an alternative method of captioning the flip chart papers you may write the title of each session on each one: Introduction to Inclusion, Early Brain Development, Screening Young Children, The Child Who Seems Different: Meeting Special Needs, etc. This activity helps refresh memory of the topics discussed in the sessions.

VIII. **Conclusion and Evaluation** (10 minutes) – Trainer can review major points and ask if there are any questions. When questions are finished hand out and collect evaluations. Everyone present is recognized for their participation with decorative certificates indicating the number of hours of training they have completed.

References

Basil, N. (1993). *ABC's of Inclusion* [Video}. Funded by the Texas Planning Group for Developmental Disabilities. Produced by Dependent Care Management Group.

Rogers, J. B. & Ellzey, M. (1996). *Inclusion of Children with Special Needs in Early Education & Care Environments: A Replication Manual*. Tallahassee, FL: The Florida Children's Forum.

POSITION ON INCLUSION

DIVISION FOR EARLY CHILDHOOD
OF THE
COUNCIL FOR EXCEPTIONAL CHILDREN

ADOPTED: April 1993, Revised December 1993
Reaffirmed, 1996, and Updated, 2000

Inclusion, as a value, supports the right of all children, regardless of abilities, to participate actively in natural settings within their communities. Natural settings are those in which the child would spend time had he or she not had a disability. These settings include, but are not limited to home, preschool, nursery schools, Head Start programs, kindergartens, neighborhood school classrooms, child care, places of worship, recreational (such as community playgrounds and community events) and other settings that all children and families enjoy.

DEC supports and advocates that young children and their families have full and successful access to health, social, educational, and other support services that promote full participation in family and community life. DEC values the cultural, economic, and educational diversity of families and supports a family-guided process for identifying a program of service.

As young children participate in group settings (such as preschool, play groups, child care, kindergarten) their active participation should be guided by developmentally and individually appropriate curriculum. Access to and participation in the age appropriate general curriculum becomes central to the identification and provision of specialized support services.

To implement inclusive practices DEC supports: (a) the continued development, implementation, evaluation, and dissemination of full inclusion supports, services, and systems that are of high quality for all children; (b) the development of preservice and inservice training programs that prepare families, service providers, and administrators to develop and work within inclusive settings; (c) collaboration among key stakeholders to implement flexible fiscal and administrative procedures in support of inclusion; (d) research that contributes to our knowledge of recommended practice; and (e) the restructuring and unification of social, educational, health, and intervention supports and services to make them more responsive to the needs of all children and families. Ultimately, the implementation of inclusive practice must lead to optimal developmental benefit for each individual child and family.

Endorsed by NAEYC - April 1994, April 1998
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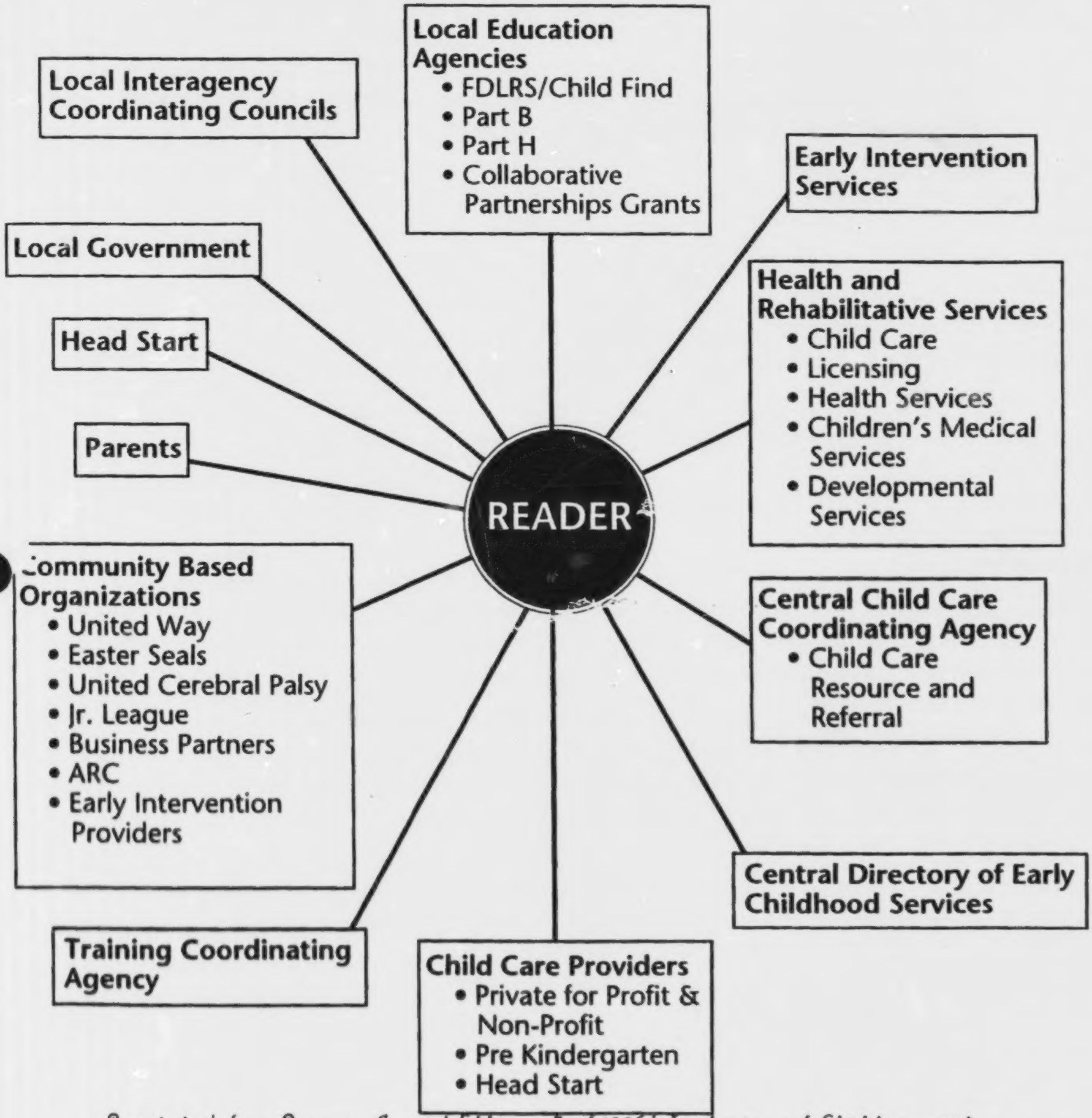
Collaborative Partners



READER

Local Education Agencies
- FDLRS/Child Find
- Part B
- Part H
- Collaborative Partnerships Grants

Local Interagency Coordinating Councils

Early Intervention Services

Local Government

Head Start

Health and Rehabilitative Services
- Child Care
- Licensing
- Health Services
- Children's Medical Services
- Developmental Services

Parents

Community Based Organizations
- United Way
- Easter Seals
- United Cerebral Palsy
- Jr. League
- Business Partners
- ARC
- Early Intervention Providers

Central Child Care Coordinating Agency
- Child Care Resource and Referral

Central Directory of Early Childhood Services

Training Coordinating Agency

Child Care Providers
- Private for Profit & Non-Profit
- Pre Kindergarten
- Head Start

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T-II-9

Collaborative Partners

1. List the contact people you know in your community who provide the services identified on the Collaborative Partners diagram.

2. List the projects with which you have already worked with these people.

3. List the collaborative partners identified on the diagram who you do not know.

4. What barriers exist to including them in your collaborative network?

5. What needs to happen to remove those barriers?

6. List any other collaborative partners in your community who are not shown on the diagram but who are critical to the success of inclusion programs.

7. What resources do they have to contribute?

8. What barriers exist to including them in your collaborative network?

9. What needs to happen to remove those barriers?

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◆ACTIVITY II.1◆

The activity that follows will help the reader:

- begin to get a picture of the collaborative partnerships that are necessary for successful inclusion programs
- identify the partnerships that currently exist in her/his community
- identify the partnerships that need to be cultivated

Identifying those members of your community who will actively participate is key to the development and continued success of any inclusion efforts. Some of these people will vary from community to community; however, some key players in every community should be included. The diagram on the next page illustrates the necessary linkages for any community interested in bringing resources together to support inclusion.

Review the collaborative partners diagram on the next page and answer the questions that follow.

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The NAEYC Annual Conference in **New York City, November 20-23, 2002** will be the largest education conference in the world. Early childhood professionals will be able to choose from hundreds of working sessions and exhibits, and experience the latest developments in education for children from birth through age 8. Click here for more info or online registration...

- **Helping Children Cope with Disaster--One Year Later**
Advice for parents, teachers and other adults for giving young children the emotional support they may need on the anniversary of September 11...

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Address ____

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E-mail address ____

Home phone ____/ ____________________ Work phone ____/ ____________________

Check one: ____ New membership ____ Renewal (ID# ______________________________)

Choose the membership option best for you:

Choose **Affiliate** OR **Independent** membership (NAEYC encourages Affiliate membership, as it includes benefits provided by early childhood associations affiliated with NAEYC in your state). Then choose **Comprehensive, Regular** or **Student** level. Check one of the six shaded boxes in the table below. Note: all memberships include a subscription to the journal *Young Children.* Comprehensive members receive additional publications.

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National Network for Child Care

Caring for Children with Special Needs:

Feeling Comfortable

Doreen B. Greenstein, Ph.D.
Developmental Psychologist
Cornell University Extension Service

Copyright/Access Information

This series of publications, Caring for Children with Special Needs, is for caregivers who are, for the first time, going to be taking care of children with special needs due to a disability, disease, or other condition. First, let's remember that all children have special needs.

You may or may not have had contact with people who have special needs. Your previous experience may impact how you feel about having a new child with special needs in your program. Some of us have been taught to avoid, glance away from, or ignore people with disabilities. The avoidance may be because we don't know how to act or what to say. We may be afraid of making a mistake. Sometimes when we see a child with a disability or other special need, we feel sad. Sometimes we wonder, "What would I do if I were that child's parent?" Sometimes we feel a bit guilty because our own children are "normal."

These or other negative feelings are to be expected. They are not good or bad, but they need to be acknowledged. It is important to avoid letting these negative feelings dominate your attitude or your efforts with a child who has special needs.

Myths about disability

- *Myth: A child with disabilities is a special gift from God.*

If parents hold that belief, fine, and you should respect it. However, from a caregiver's point of view, this is not a productive attitude. Treat and care for this child as you do all the other children in your care.

- *Myth: A child with disabilities is God's way of punishing a parent.*

Do not subscribe to, encourage, or tolerate this attitude! Children are children. They are all treasures-sometimes challenges-never punishments.

- *Myth: A child with disabilities is to be pitied.*

Pity is not productive. Support is productive, so is love and positive encouragement. Pity doesn't help a child develop into the most-and best-that she or he can be.

- *Myth: You have to be an expert to take care of a child with disabilities.*

Don't diminish the value of your experience with other children when you evaluate your ability to care for a child with special needs or disabilities. The "experts" can answer the difficult questions, but this child is a child first, and the diagnosis then becomes secondary.

- *Myth: Children never should be allowed to ask about other children's disabilities.*

Nonsense. How can we teach our children to live in a society rich in diversity if we don't allow them to ask about differences? Natural curiosity is to be encouraged, but frame your answers positively.

Strategies for inclusion

Not all feelings or beliefs are negative. There are some very positive feelings that you will likely experience, too. When you get to know a child, you will accept and appreciate him or her just as you do other children in your care. In her book (well worth reading, see "Technical references" section), *A Place for Me*, Phyllis Chandler includes a description of meeting a new child.

> Debbie, a child care staff member, was on the playground with a group of children. Her supervisor, Ann, approached her with a new boy named Andrew. Today was Andrew's first day at the child care center. He was unable to walk or talk. Ann asked Debbie to involve Andrew in the outdoor play activities. Debbie had met Andrew when he arrived, but now she was panic-stricken. "What do I do with him?" she wondered. "I've never been around a child who can't walk. How can he play on the playground? What if he gets hurt? Debbie held Andrew for a few minutes and talked to him as she reflected on the situation. She had noticed earlier in the classroom that Andrew crawled quite well, so she took him to a long tunnel that was part of the play equipment. Andrew laughed delightedly as he crawled to the other end of the tunnel where Debbie was waiting for him.

The story goes on to describe how Debbie helped support Andrew while he kicked a ball in a game with the other children. Like Debbie, most of us have the ability not only to handle children with special needs successfully, but to increase our own growth and learning in the process. When you work with children, so much depends on your attitude toward an individual child. Your expectations for children come from your knowledge of typical development along with a positive attitude toward the potential for children with special needs to grow and learn.

In planning for a child with special needs, you will want to meet the child and his or her parents to get to know them. A home visit might be possible, or a visit to your child care facility. This will give you an opportunity to become acquainted with the child instead of only the disability. Talk to the parents about the child's strengths as well as weaknesses. You will probably want to go to your library, advocacy group, or school system to find resources about the child's disability. But remember that knowing the child's diagnosis may not give you much information about an individual child, because children with the same condition can have a broad range of abilities.

After you become familiar with the child's abilities and needs, evaluate your program setting and make changes if necessary. Remember, you may not need to make any changes in your program. Often, an environment that suits children with typical needs also suits children with special needs.

Depending on the child, you and your staff may have to make decisions about one or more of these concerns:

- modifications to the environment and/or equipment and materials,
- behavior management techniques,
- continued attention to accessibility and full participation as the child develops,
- staff orientation to ensure coordinated and supportive inclusion,
- working with the child's therapists and specialists,
- introducing the child to the other children and answering their questions,
- emergency procedures, such as fire drills, that may have to be modified,
- physical needs, such as being lifted, closer supervision, or help at mealtimes,
- caring for specialized equipment, such as example hearing aids or braces,
- communicating with the child or helping the child communicate with others,
- accommodations for outdoor play or field trips,
- toileting procedures,
- special diets or feeding techniques,
- possible additional communication with parents, and
- handling emergency medical situations.

Other considerations

As important as any special techniques you might need, however, is your belief in and acceptance of every child as a special person with the potential to grow and develop. Here are some suggestions that might help when you work with children who have special needs.

If a child with special needs is coming into your home or your center, find out as much as you can about what you can do to make the child welcome. But do it in a positive way-psych yourself **up**, don't psych yourself **down** for the arrival of this child.

There may be times when you have a physical response after meeting a child with a disability who is visibly different, such as burn scars, limb amputations, or congenital differences. You may get a feeling in the pit of your stomach, tears in your eyes, or your breath may catch. Feel it, acknowledge it, and get on with the business of making friends with the child. Once you get to know a child, you will see the inner wonderfulness of this child, not the outer differences.

There also may be times when you have grown to love a child with a chronic illness or disability and the condition worsens. The child may require more complex care than you can provide, or the child may die. If this happens, seek support for yourself. Most communities have mental health professionals affiliated with a clinic or school who can help you and your staff with your grief. Don't ignore the grief or pretend it's not there.

Regardless of the size of your community, there are likely to be adults and other children with the same diagnosis as the child you are welcoming into your program. If possible, invite upbeat parents and older children with the same diagnosis to talk to you, your staff, and other children. Share strategies, make friends, ask questions, and get answers. Remember that people with disabilities make great employees. A staff member who has a disability is a great role model for all children.

As a child care provider, you are probably aware of the struggles of working parents who juggle child care and their jobs. The juggling act can be even more complex for parents of a child with special needs. That's why honest, open communication between child care providers and a child's parents is even more important.

Remember that the children in your care look to you as a role model. If you are positive, matter-of-fact, and upbeat about a child's disability, other children will follow your lead. Some people find it helpful to pretend to themselves that this is a child from another culture; they celebrate this child's "special needs" simply as another aspect of diversity.

Resources for caregivers

There are some wonderful resources available about children with special needs. Read books and magazines, and ask the child's parents for information that you can read and share with your staff. Information also can be accessed on the World Wide Web. Try this site to get started: http://www.familyvillage.wisc.edu/search/direct.htm

Technical references

Allen, K.E. (1991). *The Exceptional Child: Mainstreaming in Early Childhood Education.* Delmar Publishers, Albany, N.Y.

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More information

This publication is part of a series, Caring for Children with Special Needs. You may find other fact sheets in this series with helpful information.

- Caring for Children with Special Needs: The Americans with Disabilities Act
- Caring for Children with Special Needs: Allergies and Asthma
- Caring for Children with Special Needs: Attention Deficit Disorder
- Caring for Children with Special Needs: Challenging Temperaments
- Caring for Children with Special Needs: Chronic Illnesses
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- Caring for Children with Special Needs: Hearing Impairments
- Caring for Children with Special Needs: HIV or AIDS
- Caring for Children with Special Needs: Physical Differences and Impairments
- Caring for Children with Special Needs: Seizure Disorders
- Caring for Children with Special Needs: Speech and Language Problems
- Caring for Children with Special Needs: Visual Impairments

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The Enterprise Zone-Preschool Inclusion Project

Family Childcare Component

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Family Childcare Component

Major Concepts and Content

The intent of this component was to emulate the instruction and technical assistance available through this project for preschool facilities for family childcare homes. This required more than conducting the same training for different attendees. Family childcare is a unique industry with the intricacy of a formal childcare arrangement within the informal setting of a private home. Additionally there are many good models to follow without one specifically correct procedure. Training and technical assistance must be generalized to the nature of the profession overall and tailored to each individual provider. The project manager was the instructor for the training and worked individually with the providers in their homes. Problem solving phone conversations were also an integral part of the program.

Throughout the country there are vastly different requirements for operating a family childcare home. These vary state-by-state and county-by-county and range from on-site inspections to monitor compliance with health and safety issues and to by-mail registration only. The number of children permitted also varies. This project was designed for providers in a county with mandatory licensure limiting the number of preschool aged children to 6 if none are less than 12 months of age. Caring for children from birth to age 12 is permitted but the numbers of children permitted are based on the presence or absence of infants less than 12 months of age.

Recruitment

Family childcare homes are not as easy to identify as commercial childcare centers and soliciting them to participate required several strategies. The local licensing division of the Florida Department of Children and Families was contacted for a listing of all licensed providers within the county. The local coordinated community childcare agency (4 C agency), which provides resource and referral (R&R), contracting with caregivers to provide subsidized services, monitoring and technical assistance for these subsidized arrangements was also contacted for a list of licensed homes arranged in zip code order. These contacts were handled through phone calls to the director of the R&R, and licensing unit supervisor to explain the nature of the project. Additionally, a newsletter and informational flyers were included in bulk mailings from the 4C agency to all subsidized/contracted providers.

Family childcare professional organizations were targeted for presentations during their monthly meetings and distribution of informational flyers. These associations generally have ties to the local R&R or can be located by contacting the National Association for Family Childcare, which can provide a listing of area associations. Again, this can be handled by a phone call to the NAFCC office at 515-282-8192. Their address is NAFCC, P.O. Box 10373, Des Moines, Iowa, 50306, e-mail: nafcc@nafcc.org - website: http:/ / www.nafcc.org.

Our target areas were chosen for research purposes and were specifically federally designated Enterprise Zones. However, no provider interested in participating was turned away. The target areas evolved into areas surrounding the childcare facilities participating in the center-based component.

Training

Four series of training sessions were held, three in English and one in Spanish. With the first group, the sessions began in a neighborhood community building. However, the participants suggested and offered their homes for the remaining class sessions and this practice continued until the course concluded. Meeting in the family childcare providers homes proved to be beneficial by creating a relaxed environment for bonding of the members and also gave the provider an opportunity to show their set-up to others in the business. This was the only group to adapt the sessions in this manner although the opportunity was suggested for subsequent groups.

The core of the training offered was *Second Helping: An AdvancedCurriculum for Family Childcare Providers* and *Cuatro Pasos A Una Profesion,* which is the Spanish adaptation of this course. *Second Helping* is a nationally recognized 32-hour advanced training course developed for family childcare providers to be taught by certified family childcare instructors. It is respected as a valid means of further advancing the professional skills of family childcare providers who have previously attended basic courses and numerous workshops covering topics of health and safety, toys and equipment and other introductory level skills. *Second Helping,* while reflecting a tone of informality integrates self help and other strategies from a range of sources. It provides a sense of being part of a profession and helps providers appreciate the importance of their contribution to children and society.

The course is divided into four 8-hour modules; The Provider, The Business, The Family and The Children (session objectives and outlines are attached). Each module has a corresponding manual, which ends with a review quiz and includes evaluations of the workshop material and the presenter. The course involves some interactive and problem solving exercises and discussions as well as lectures. It was developed to be group training with the number of participants recommended for optimum interaction at maximum of 25 and no fewer than 5 at a minimum. The smaller numbers in a class will condense the actual training time required. The quiz at the conclusion of each module allows for immediate assessment of provider understanding. This course maintains a high integrity and can be adapted to fit within the program content of the National Child Development Associate credential.

The curriculum design is geographically sensitive, depending on the developmental level of the provider population in any particular location. For instance, in some regions of the country, the section on fine-tuning contracts, policies, and intake interview techniques is one of the most popular sections in the course. In other areas, particularly where regulation mandates policies and contracts, this section is less in demand. Certified *Second Helping* instructors have completed a required train-the-trainer course and are prepared to offer menu choices that allow the curriculum to be customized to meet the needs of a given provider population.

The *Second Helping* curricula did not contain sufficient material on recent brain development research, the issues of inclusion, developmental delays and working with children with special needs to meet the specific objectives of EZ-PIP. As part of our project training, information regarding ADA legislation, inclusion, the responsibilities of the family childcare provider, adapting the environment, observation and assessment as a form of intervention with emphasis on developmental delays was added. This material was developed for the project center based training. When presented in the *Second Helping* or Cuatro Pasos sessions, the application and adaptation for family childcare homes was discussed. Home visits by the project manager/mentor/instructor also provided an opportunity to examine the specific requirements for each provider's arrangement and children in care. These topics and issues have been added to the revised edition of the Second Helping curriculum.

For further information about presenting Second Helping or Cuatro Pasos in your community contact Pathfinders Unlimited, Inc. 600 Southwest 29th Avenue, Fort Lauderdale, Florida 33312, (954) 587-6735, pathfinders@laker.net.

An informational brochure is included.

Module 1 - The Provider

Objective

Family childcare providers have responsibilities to fulfill with their families, clients, children in care and businesses. The output of energy is tremendous. Many providers approaching 'burn-out' describe the 'empty-cup' syndrome. This module becomes the foundation for the remaining modules by focusing on the provider.

The goal of this module is to encourage providers to turn their nurturing qualities inward and begin to refill the empty cup. Emphasis is placed on the individual provider and the need for a strong personal foundation in order to remain happy and healthy. An investment in the provider's well being also insures consistent, quality childcare.

Module I offers exercises for self-assessment and skills in the areas of self- esteem, assertiveness, interpersonal communication and conflict resolution. The concept of customization is also introduced; providers will learn techniques for customizing their business to meet preferences and lifestyle, promoting what they do best. Stress levels and burnout identifiers are used to teach accompanying stress reduction and burnout prevention techniques.

This module concludes with a celebration of family childcare, helping providers gain a new perspective and pride in their profession.

Curriculum Outline – The Provider

1 Elements of self-Esteem

- Importance of Self-Esteem
    - Who Are You…Really?
- Why Self-Esteem is an Issue for Family Childcare Providers
    - Nurturing Qualities
    - Professional Self-Esteem Obstacles
- Understanding the Elements of Self-Esteem
    - The Language of Self-Esteem
    - Understanding Definitions
- Self-Image
    - Where Did We Get It?
    - Is It Who We Really Are?
    - What is Its Function?
- The Affect of Inaccurate Information
    - Limitation
    - Avoiding Limitation
- Self-Esteem
    - Constantly Changing Constant
- Self- Talk
    - Negative Self-Talk
    - Resistance to Change
    - The Consequences of Change
    - Positive Self- Talk Skills
    - Sample Affirmations
    - How to Use Affirmations

2 Communication

- The Value of Communication
- Communication Techniques
    - Communication Concepts and Techniques
    - Tips for Successful Communication
- Assertiveness

    - Definition
    - Assertive Premises
    - Assertive Ingredients
    - The Process for Assertive Communication

- ◇ Communicating Through Conflict

3 Your Style, Your Business

- ◇ How Family Childcare Has Impacted Your Life
    - Provider Longevity
    - Balance -Positive Versus Negative
    - Adaptability, Flexibility, Because You Can

- ◇ Your Changing Needs
    - Changing Ages, Changing Times

- ◇ Personal Profile
    - Family Childcare Questionnaire
    - Lifestyle Inventory
    - Life Pie

- ◇ What and How to Change
    - Possible Adjustments
    - Choices in Customizing
    - Planning for Change
    - Transition

4 Refilling Your Cup

- ◇ Definition of Burnout

- ◇ Overview of Stress and its Effects
    - What is Stress?
    - What Triggers Stress?
    - The Many Faces of Stress
    - Fatigue and Stress

- ◇ Life Stress Inventory
    - Life Event Scale
    - Stressful Attitudes Assessment

- ◇ Stress and Family Childcare
    - Family Childcare Stress Checklist
    - The Ebb and Flow of Family Childcare
    - Situational Overload
    - Personal Crisis and Family Childcare

- Staying Healthy
    - Modeling Health
    - Business Survival
    - Knowing Your Limits

- Burnout Prevention
    - Stress Release Valves
    - Coping and Relaxation Skills
    - Learning to Nurture Yourself

5 Coming From A Higher Place

- Making a Difference in the World
    - Impacting Children
    - Impacting Families
    - Impacting Society
    - Impacting the Future

- Provider Bonuses
    - Coming From a Higher Place
    - I'm Unique/ Special Because

Suggested Reading List

Summary Review

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Objective

This module blends the nurturing and business sides of family childcare. Sound knowledge of business management skills is important to the successful operation of a family childcare home. Many providers with strong skills in other areas are unprepared to deal with the business practices that assist in the smooth operation of a small business.

Dealing assertively with clients may also be uncomfortable to providers who are attracted to family childcare for its loving, nurturing aspects. The mind set that "loving for a living" and business are mutually exclusive prevent many from viewing themselves as viable small business operators, and successfully marketing themselves as such.

Longevity, and the quality of care offered, may also be greatly affected by how providers perceive their professionalism. If providers feel professional, they will naturally seek out opportunities for growth and development. In addition, society's frequently negative view of family childcare may create frustration if providers feel powerless to affect change.

The goal of this module is to empower providers by teaching them to advocate for themselves, their business, and their profession. Providers are given a solid footing in the global picture, including the importance of provider unity, a perspective on the history of childcare in the United States, statistics affecting childcare, and the current high visibility.

Module II makes a solid case for viewing family childcare as a profession - examining the criteria, issues, and benefits of professionalism. With this foundation, effective business practice, and management skills specific to family childcare are identified, including marketing techniques for the small business operator. The importance of compliance and creating a rapport with regulatory agencies (where they exist) is presented, in addition to local reporting procedures for child abuse/neglect. Module II offers a customized approach to familiarizing providers with local and state resources, as well as national support and information resources.

This module concludes with an overview of the career path versus the career ladder concept, provider association involvement, and credentialing opportunities available for providers.

Curriculum Outline – The Business

1 Unity Of The Voice

- High Visibility In The Nineties
    - Current Statistics Affecting Childcare
- The Window Of Opportunity
- History Of Childcare In The United States
- The New Wave Of The Future
- Unity Within Diversity

2 Professionalism

- Family Childcare In The U.S.
    - Defining Family Childcare Concept
    - Common Ground -The Unity Within Diversity
    - Issues In Professionalism
    - Criteria For A Profession
    - Issues In Professionalism
- Benefits In Professionalism
- Representing Family Childcare
    - Professional Trade Associations
    - Support Agencies
    - Professional Support Systems

3 Business Management

- Bringing In New Clients
- Telephone Inquiries
- Intake Interviews
    - Intake Checklists
    - Intake Checklist Suggestions
    - Philosophical Letters And Provider Portfolios
    - Sample Philosophical Letter
- Written Agreements
    - Policy Agreements
    - Policy Agreement Suggestions

    - Sample Policy Agreement
    - Contracts (Parent/Provider Agreements)
    - Contractual Agreement Suggestions
    - Sample Parent/Provider Agreement (Contract)
- ◇ Observation Visits
- ◇ Evolving And Customizing
    - Ongoing Communication
    - Sample Ongoing Communication Technique
- ◇ Sick Childcare
- ◇ Termination
    - Termination Process
- ◇ Collection
    - Steps In Collection
    - Sample Collection Letter
- ◇ Vacation Plan
    - Cathy's Vacation Plan
- ◇ Hiring And Training A Substitute/ Assistant
- ◇ Information Resources

4 Regulatory Considerations

- ◇ Regulation And Rationale
- ◇ Regulatory Agencies
    - Creating A Positive Rapport
    - What To Do When You Have A Problem
- ◇ Advocating For Change
- ◇ Reporting Child Abuse/Neglect

5 Marketing Yourself

- ◇ Creating An Identity
- ◇ Business Cards And Flyers
- ◇ Networking For Clients

6 Career Paths

- ◇ Career Ladder Vs. Career Path
- ◇ Why Career Paths Work Well For Family Childcare
    - Career Path Options For Family Childcare
- ◇ Associations And Career Paths
    - CAFCC Career Path Options
    - Association And Career Paths
- ◇ Furthering Your Career Path As A Family Childcare Provider
    - NAFCC Accreditation
    - Child Development Associate
    - Master Provider Credential

Suggested Reading

List Summary Review

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Module III - The Family

Objective

One of the key elements in family childcare is "family." The provider's family becomes the loving foundation upon which the security and mutual interests of other families are built.

There are several families to consider: the provider's family, the client families, and the special family that is created by the provider and the children in care. Often the provider becomes the primary focus in all of these families. Providers may feel overwhelmed at times, by the push and pull of trying to balance the needs and everyday crises of their own families with those of their diverse client families - on top of the everyday stressors of family childcare.

The goal of this module is to celebrate the diversity of family childcare homes and families, while offering ideas, concepts and workable solutions for the successful blending of all the families involved. Providers are also encouraged to broaden their definition of "family ," through an overview of the constellation of families in our society. A discussion of healthy family traits is included.

Providers will be offered the skills to more successfully integrate their own families into the childcare business and still safeguard the family unit. Module III offers creative, yet practical coping skills. Time management skills that can be used to improve the flow of their home and increase time available with their own families are also present.

Module III moves from the provider's family to the client families and teaches positive techniques for successfully integrating client families into their childcare. Providers learn a new understanding for working parents, along with communication approaches. Using previously presented conflict resolution skills, providers review common conflicts with clients and possible solutions.

Identifying families under stress and tools for offering support, or strategies for moving them on to community-based services are also taught.

Module III closes with a look at the concept of "customized integration" within the diversity of client families with the goal of creating satisfying, win-win situations for all concerned.

Curriculum Outline – The Family

1 A Celebration Of Diversity

- Diversity In Family Childcare
- Recognizing Diversity In The American Family
- What Makes A Healthy Family?
    - Traits Of A Healthy Family

2 The Provider's Family

- Your Family And Childcare
- Coping Skills For You And Your Family

3 Time Management

- Managing Your Family Childcare Time
    - Time Management Ideas In Family Childcare
- Daily Energy Peaks And Valleys
- Time Busters
    - Time Management Tools
    - Time Management Tips
- Fun For You And Your Family
    - Fun For Families
    - Fun For You
    - More Fun For Families

4 Integrating Families - Provider And Client

- Cultural/Ethnic Diversity
    - Cultural And Ethnic Differences
- Who's That Stranger At My Door?
    - Styles Of Parenting
    - Parental Guilt And Fears
    - Common Fears And Feelings For The Family Childcare Provider
- Building And Maintaining Relationships With Clients
    - Approaching Clients

        - Attitude And Approach With Clients
        - Common Areas Of Conflict With Clients
        - Consulting With Clients

    - ◇ Families Under Stress
        - Factors Affecting Families
        - Times Of Transition
        - The Benefits Of Supporting Families Under Stress
        - Knowing Your Limits
        - Sample Referral Worksheet

5 Customized Integration

    - ◇ Understanding The Concept

    - ◇ Customized Integration In Family Childcare

    - ◇ Customized Integration And Extended Family Ideas

Suggested Reading List

Summary Review

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Objective

Family childcare is a unique environment for children - home-like, yet educational; a relaxed, natural learning environment. In the course of a family childcare day, there are many opportunities for a provider to expand upon concepts and enrich a child. A consistent caregiver can create very special relationships because of these unique qualities, inherent in the family childcare atmosphere.

Module IV begins with an overview of the windows of development. The importance of solid footing in child development and developmentally appropriate practice are reinforced. How play skills relate to the acquisition of life skills is highlighted, and the techniques for observation and recognition are presented.

The natural learning environment concept reveals the importance of the physical environment, demonstrates the hidden curriculum that exists in every family childcare home, and teaches providers to recognize the teachable moment. Providers are offered the skills for managing developmentally appropriate activities in a mixed age group.

Self-esteem is shown as not only the foundation for the special relationships created with children, but as the outcome of all daily interactions. The way a provider relates to children, or the way their mistakes are handled can affect the seeds of self-image and self-esteem in profound ways. Through the eyes of compassion providers feel more comfortable in being with children day in and day out.

The concept of therapeutic childcare is introduced, including strategies for helping children under stress. Providers will learn the importance of behavior as a communication, the difference between punitive discipline and guidance, and the skills to guide children's behavior.

Module IV progresses with a discussion of quality and quality indicators within family childcare, and concludes with a look at the personal growth that being with children brings, encouraging providers to discover the gifts children offer them in their daily interactions.

Curriculum Outline – The Children

1 Windows Of Development

- Child Development
    - Areas Of Child Development
    - How Children Develop
    - Behavior – To -Age
    - How Children Learn
    - Play Skills = Life Skills
    - Developmental Appropriateness

- Observation And Recognition

2 Natural Learning Environment

- Family Childcare As A Natural Learning Environment

- Components Of A Natural Learning Environment
    - Physical Environment
    - The Adult Role
    - The Children

- Hidden Curriculum

- Teachable Moments

- Balancing A Hidden Curriculum With Structured Activities

3 Many Way For All Ages

- Managing Individual Activities

- Managing Group Activities
    - Many Ways For All Ages
    - Time Benders

4 Children And Self-Esteem

- The Jar Theory
    - What's In The Jar When They Come To You?
    - Your Impact On The Child

- Where Do We Begin?
    - Developing Self-Esteem In Children
    - A Sense Of Trust

        - A Sense Of Separateness
        - A Sense Of Place In The World
        - Self-Esteem

5 Interacting With Children

- ◇ Mirror World In Family Childcare
    - Children Learn What They Live

- ◇ Developing Relationships With Children
    - Positive Communication
    - 100 Ways To Say "Good For You"
    - Tips On Communicating With Children
    - Creating Friendships
    - Attitude Adjustments
    - Adult Behaviors That Turn Children Off And Why
    - A Child's Bill Of Rights
    - Positive Modeling
    - Feelings
    - Modeled Learning
    - Cleaning Up Mistakes
    - Humor

- ◇ Therapeutic Childcare And Children Under Stress
    - I Can't Say, "Help"
    - Stress Reduction For Children
    - Coping Skills For Children
    - Button Pushers

- ◇ Saying Good-Bye To Children

6 Guiding And Influencing Children's Behavior

- ◇ Behavior As A Communication

- ◇ The Guidance Approach
    - Punitive Discipline
    - What Is Guidance?

- ◇ Tools For Guidance
    - Giving Up Control
    - Rules

- ◇ Guidance Techniques -Time Outs
    - Additional Guidance Techniques
    - Guidance Techniques -Consequences

Classifying Behavior

- ◇ A Partnership For Success
  - Happy Face Chart

7 Quality And Family Childcare

- ◇ Defining Quality In Family Childcare
- ◇ Quality Indicators
- ◇ Commitment To Quality
- ◇ Illustrations Of Quality

8 Growing With Children An Exercise In self-Reflection

Suggested Reading List

Summary Review

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Additional Curriculum - (8 Hours) From EZ-Pip Training

These additional hours of training were drawn from the EZ-Pip curriculum. The objective was to provide training to family childcare providers in the inclusion of children. A needs assessment for the group can be implemented prior to selecting these additional sessions. For the Family Component of EZ-Pip project the sessions included were:

Session 2: Early Brain Development
Session 3: Screening Young Children in the Classroom Setting
Session 4: The Child Who Seems Different
Session 8: Speech and Language Development

❖ At Home with Family Child Care ❖

Volume 1 Issue 1 Circulation Miami-Dade County January 1998

Welcome to the Heart and Soul of Providers

We not only open our doors to the present but we help direct the course and the shape of the future. We make a difference in tomorrow.

Welcome to the first edition of *At Home with Family Child Care*. This newsletter is all about being a family child care provider. Whether you are a brand new provider or seasoned veteran, young or not so young- we all share a common bond. We work for and in the best interest of the children in our care

This publication will offer updates on issues relating to our industry as well as helpful hints from our readers. There will probably be an editorial comment, or two and certainly things to do with the kids in our care. However, the content will be based on provider input and promises to reflect the heart and soul of the family child care providers in our community.

In our county there are almost 300 family child care providers? How many do you know? How many are neighbors?

Do you ever think about all the things you do in one day that no one but another provider would ever understand? Did you ever want just to hear another person say, "Me, too!?"

Did you know there are two provider associations locally, one serving the north area and one reaching down into the south?

Did you know you have regional representatives working to present your concerns to the state?

Did you know both local associations are part of the Florida Family Child Care Home Association, Inc. (FFCCHA, Inc.)?

Do you realize FFCCHA, Inc. was a major player in getting the ratio of children changed which resulted in the recent increase across the state?

Did you know the very rules that govern your business are about to be rewritten (Chapter 10M-10)?

Did you know one provider can do alot in her own home but almost 1000 providers across the state can change the law!?

Did you know - you didn't know some or most of this?!

Welcome to the Heart and Soul of family child care. We hope you will find interesting and important information about your work in this newsletter.

Your comments, concerns and feedback are always welcome. After all you are ***At Home with Family Child Care.*** ***See page 4 on how to submit your own articles, comments or current information.***

Inside This Issue

Provider Thoughts *page 2*
Things to do *page 3*
Coming Events Calendar *page 4*
To submit your ideas *page 4*

and did YOU KNOW . . .

Last summer in Florida, there were issues unfolding that will affect each and every family child care provider, licensed or registered, through out our state.

Early in July, the Orlando Sentinel reported effective July 15 of this year, the JUA (Joint Underwriters Association) would no longer write homeowners insurance for persons caring for more than three children in their home, even though the state standards allow for up to ten children. Furthermore, effective in September, 1997, they would no longer renew homeowners insurance for providers caring for more than three children. This, of course, sent chills thorough the family child care field.

On July 10, 1997 the JUA held a meeting in Tampa where the President of the FFCCHA (Florida Family Child Care Home Assoc., Inc.), Mary Tingiris, the Chief of Child Care Services with the Dept. of Children and Families (formerly HRS), Larry Pintacuda and Manager of Hillsborough Child Care Licensing, Linda Stoller spoke on behalf of the industry of family child care. The extremely costly concern of losing their homeowners insurance while operating a perfectly legal child care business within their home was presented.

In light of the recent change in welfare and the increased need for odd-hour and evening child care, which is usually handled in a home not a center, would certainly be hindered by the providers leaving child care in order to keep their homes! The decision not to insure family child care providers threatened not only the providers but the families of the children already in their care. Where would all the children go?? How many people would start caring for children under the table?

(con't on page two)

Homeowners Insurance Crisis Put on hold (con't. from page one)

The Executive Director of the JUA, James Newman, stated he had never heard of family child care before the article had appeared in the Orlando Sentinel. When the providers of the state put the telephone tree into action not only did we get the attention of the Governor's office but we had the Insurance Commissioner's office staff asking some important questions, like -*Who are these people and why are they calling us!!!?* They couldn't say they never heard of family child care from that point on.

In August, the JUA voted to offer homeowners insurance to providers who are providing care within the ratio as set by the state standards, (four infants or six preschoolers or five preschoolers and five schoolage children or any of the possible combinations allowable). This is certainly an accomplishment.

For the last five years or so providers have been asking the different agencies for assistance with this critical problem. Over and over again, providers were losing their homeowners insurance if they let it be known they were operating a child care business from their home.

Over and over again- we were told if you can prove this is the reason for being cancelled or not renewed and if those providers had a separate liability when they were cancelled- we'll make them reinstate the policy. Unfortunately these policies were cancelled without specific reasons being given. It was the unsolvable problem. Until a journalist broke the story and the phrase- "We don't tell our homeowners" hit the headlines. Our low profile was gone!

However, this problem isn't over. The JUA doesn't speak for all the other private companies. It may just wind up that in order to keep any homeowners policy, anyone providing child care will HAVE to have liability insurance. While it probably won't be required by the state - it will probably be required by the insurance industry. Time will tell. But for now those with JUA policies and liability insurance are secure.

Perhaps a good idea for those providers operating without liability insurance is to start a 'just in case fund' for purchasing this type of insurance. A Plus has recently begun to offer financing plans for purchasing policies. This certainly is a welcomed relief for those who need a time payment plan and for those currently working to help finance providers as a courtesy. More on this as news develops, and don't blink!

The recently conducted senate investigation has produced a proposed piece of legislation that will hopefully end up protecting the homeowner's insurance policies without forcing mandatory liability insurance coverage for every provider. This is still being debated and we won't know the answer until after the next legislative session. Save your pennies and stay tuned.

The days of don't tell are over. Now it's time to start saving for a FCC liability policy.

From the thoughts of. . . Katie Williams

Change or Changes, Changes or Change

Most of us find it very difficult to manage change, frequently you will hear terms such as: "We have done it this way for many years, and why should we change now?" We would say my mother or father or teacher did it this way.

When making change, individual feelings must be taken into consideration. Be gentle with other folk's feelings, but they couldn't care less about yours or mine.

Webster defines change in many ways: I especially like these;

1. *To give a different position, course of direction*
2. *To pass from one phase to another and to engage in giving something and getting something in return (so what do we get?)*

Ask yourself if it could be done better using another method? Or could someone else do it better? If so, don't be afraid of change. Remember, we are making changes for our future and the young children. That is our main GOAL.

THE UNIVERSITY OF MIAMI
MAILMAN CENTER FOR CHILD DEVELOPMENT

Enterprise Zone - Preschool Inclusion Project

EZ-PIP

Promoting the Inclusion of Children with Special Needs into Quality Child Care Centers and Family Child Care Homes

Come and learn how inclusion is coming to Dade County and how it affects your Child Care Center or Family Child Care Home

◆

We offer a comprehensive program for family child care providers, child care center staff and administrators to include children with disabilities in their classrooms and family child care homes.

There are provisions for the hiring of substitutes to allow teachers and providers to attend training. Assistance is also provided for NAEYC and NAFCC Accreditation, CDA hours and more.

◆

Children should learn together. Children with special needs should have the opportunity to attend quality early care and education settings with their peers in their own neighborhoods . Please help us make that possible.

FOR MORE INFORMATION PLEASE CONTACT DR. GOLD'S OFFICE
Phone (305) 243-6624 Fax (305) 243-5978

Child Care Center Project Manager, Faye Farnsworth   Family Child Care Project Manager, Michele D. Scott

In collaboration with Metro-Dade Offices of Community & Economic Development, & Child Development Services, & Family Central.

Upcoming Events for Family Child Care Providers

Local Association Meetings:
Family Child Care Providers Assoc. of Dade County meets the first Saturday of every month at 3750 South Dixie Hwy. at 10:00 am, call **223-8335** for more info
South Florida Home Child Care Assoc. meets the second Saturday of every month at 5400 N.W. 22nd Ave at 10:00 am, call **693-8815** for more information
State Association Meetings:
Florida Family Child Care Home Assoc. next quarterly meeting is Feb 7th, in Leesburg, call **1-800-581-1192** for info
Special Events in February/March:
Governor's Summit on Early Care & Education Feb 12th in Orlando, for registration info call **1-800-423-6786**
Children's Week in Tallahassee runs March 30th thru April 2nd -you gotta see it to believe it! call 1-800-423-6786 for event schedule. For related local events, call Family Central 908-7300 or Child Development Services 375-4670 ask for the FCC coordinator.

Announcing . . .

Second Helping

an advanced curriculum for providers taught by certified provider instructors

Coming in the Spring !!
Two locations- North & South

Limited Scholarships will be offered for qualified applicants

call 243-6624 or 322-6059 for more information

How to respond to *At Home With Family Child Care*

Most newsletters are not written to line bird cages! The information written in this publication is for and about you, the family child care provider. What will make this newsletter special is it will come from you about the work you do. Please address your comments, activity ideas or upcoming events to:

Mailman Center for Child Development
University of Miami School of Medicine
1601 N.W. 12th Avenue #4015
Miami, Florida 33136
Attention Newsletter Editor

All submissions become the property of the publisher and the editor reserves the right to edit or correct the copy received, as necessary. Credit to the author will be given. Keep those cards and letters coming- Your name would look great in print! Write today!!

MAILMAN CENTER for CHILD DEVELOPMENT
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1601 N.W. 12th Avenue, #4015
Miami, Florida 33136

Family Child Care Provider
Address
Label

At Home with Family Child Care is published bi-monthly highlighting appropriate practices and issues of inclusion for family child care providers by the staff of the Enterprise Zone-Preschool Inclusion Project (EZ-PIP). This project is a four-year grant funded by the Department of Education Office of Special Education.
Director: Susan Gold, Ed.D., Assistant Professor
Family Child Care Project Manager and Editor: Michele D. Scott

◆ At Home with Family Child Care ◆

Volume 2 Issue 2 Circulation -Miami Dade County September 1999

Now What??

The only thing that is consistent is that there will be change. Nothing stays the same! Some changes happen and we don't even pay that much attention to them. For example a child you see everyday changes right before your eyes and you hardly take notice until one day you are stunned with how big they have grown! Some other changes we notice right away. The TV schedule for our favorite programs- now whatever possessed them to mess with that?? There are things around us changing all the time. Many times for the greater good, and while we were comfortable with the way things were, in most cases, they will be better once we adjust to the difference.

We open our doors to the present and we help direct the course and the shape of the future. We make a difference in tomorrow.

Recently the rules for our industry made some changes. Here in Miami-Dade County some of them are hardly new and still others are quite different. While the majority of the state was offering family child care providers only 3-hours of training, we were giving 30-hours of training. Think how much more prepared people starting out here were. Imagine how much change is being felt in areas where they only had 3-hours of training to be told you MUST have this 30-hour course before you can begin! Something you might not know is the state is requiring this 30-hour family child care course to be taught by people with a direct relationship to family child care. That's right you must have a background in the field. Seems like somebody was listening to us. Our unique industry requires more than a quick train-the-trainer course to be able to lead others into the profession nationally regarded as the largest form of out-of-home child care.

Where the confusion comes in is that some providers took a 20-hour and a 10-hour child care course, which does equal 30 but not in FAMILY CHILD CARE. If you had this 20 and 10 situation, you will not get the assessment points for the 30-hour family child care course until you meet this requirement. Now calm down- in some instances common sense has prevailed!!! You will not be required to re-take the whole 30 hours- just part, and not 29 hours you skeptics!

And even better news. . . once you have taken this course you will continue to get the credit for it each time you are monitored or assessed. You will not have to re-take it each year- no confusion about this.

Another addition to training requirements came in the form of 10 additional hours for those providing subsidized child care. For the record, ANYONE taking care of children should make sure they take this short training, WHEN IT IS AVAILABLE.

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And . . . What Else??

However, many providers are confused about this course. It is not an additional 40-hours of training. It is a 10-hour add-on course that is still in the development process.

When it is complete, the course will offer information on the observation and assessment of young children. This is really important to family child care providers since we can really make a difference in the lives of the children we care for.

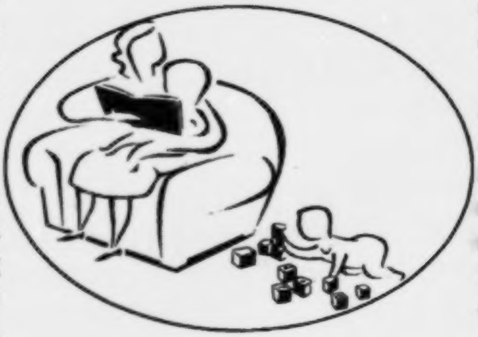
Family Child Care Providers . . . at Work

Provider Awareness

More than half of a child's physical, social, emotional and intellectual development takes place in the early years.

Did you know, nationally, the most popular form of child care for infants and toddlers is in a family child care home? With this fact in mind, add the recent brain research outcomes. Now we know the experiences that fill a baby's first days, months and years have a decisive impact on the architecture of their brains. These experiences have a direct impact on the nature and extent of their adult capacities! We really do mold the future.

It is even more understandable why we need to be able to spot areas of concern where a young child might be in need of a little more attention. Additionally, we need to be confident enough in our own knowledge to convince a parent to seek further assistance for their child. Many of the developmental delays if discovered early on can be caught up, so to speak, before the child enters kindergarten. We all know situations where the child was not considered for special help until grade-school and then never fully caught up with his peers.



When needs and concerns are identified during this time

Early Intervention

provides families with services that will help their child reach full potential.

When you think of all the possible benefits that will come from being a little more aware; less heartache for the parent, less public dollars spent for years of special instruction and a more fully capable, self-confident child and productive member of society, doesn't it make sense to find out about the recent developments in the field of early care and education?

Any child from birth to 36 months, who has been determined by a developmental evaluation to have a developmental delay or other challenging condition may qualify for early intervention services.

There are many services available based on the needs of the infant or toddler; hearing, vision, medical, nutrition, social work, psychology, nursing, speech and language, service coordination, parent education and counseling, physical and occupational therapy, and transportation to receive services available at no cost for those who qualify.

Having information about the resources available to parents is also very important.

Bits and Pieces

FREEFREEFREE

Family Child Care

Second Helping Training

When: starting Saturday, October 23, 1999

the entire course is 40 hours over the next 5 Saturdays

from 9:00 to 5:30 pm (lunch included)

Where: Family Central - Miami Lakes Office

15804 NW 57th Avenue

Why: the best thing you'll *ever* do for YOU!

This course will be taught by

Michele D. Scott, M.S.

former family child care provider

For further information and enrollment please

call 305 322-6059

Upcoming Events

Local Association Meetings: These groups meet in various family child care providers homes throughout the county. Don't miss this opportunity to meet, greet and share a good time with friendly people. **Call Today**

Family Child Care Providers Assoc. of Miami-Dade County– (south county) meets the first Friday evening of every month from 7:00 pm, for more information call Maria Luaces at (305) 223-8335

South Florida Home Child Care Assoc. (north county) meets the second Saturday of every month from 10:00 am, for more information call Katie Williams at (305) 693-8815.

State Association Meetings:
Florida Family Child Care Home Assoc (statewide) has quarterly meetings in Ocala. For further information call (954)-581-1192

Training Opportunities

Cuatro Pasos A Una Profesion

The Spanish Language Adaptation

Second Helping

an advanced curriculum for providers taught by a certified instructor

Coming in the Spring !!

Limited Scholarships will be offered

Call for more information
(305) 322-6059 or 243-6624

Building Babies' Brains

Is Coming To FCC Soon!

FAMILY CENTRAL, INC.
13850 N.W. 26th Avenue
Opa-Locka, FL 33054

In cooperation with

MAILMAN CENTER for CHILD DEVELOPMENT
University of Miami Department of Pediatrics
1601 N.W. 12th Avenue #4015
Miami, Florida 33136

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Director: Susan Gold, Ed.D.
Family Child Care Project Coordinator: Michele D. Scott, M.S.
(305) 243-6624 (305) 322-6059 fax (305) 243-5978

Department of Children and Families
Licensing Guidelines
For

Family Child Care Homes

65C-20 Standards

How To Start A Family Child Care Home

A Comprehensive Guide

Developed for Miami-Dade County by

Michele D. Scott, M.S.
Early Childhood Educator / Family Child Care Specialist
University of Miami Mailman Center for Child Development
(305) 322-6059

in cooperation with
Miami-Dade Department of Human Services
Office of Human Development
Division of Child Development Services
(305) 633-6481

Thank you for your interest in Miami-Dade County's *Licensing Guidelines* for family child care homes. These guidelines are taken from the Family Child Care Standards, Chapter 65C-20 as written by the Florida Department of Children and Families and are based on the Florida Statutes 402.301-3195. These standards are the ruling authority in Miami-Dade County and enforced by the Department of Children and Families.

WHO IS REQUIRED TO BECOME LICENSED?

Using the provider's own home as a child care setting, the number of children allowed in a child care home is limited by law. Caring for a child or children from one (1) unrelated household, does not require licensing. Caring for children in their home does not require licensing.

Licensing is required when an operator cares for children from two or more unrelated households in the family home regardless of the manner of payment being received. There are four options, but you may move from one to the other without reapplying:

a) A maximum of four children birth to 12 months of age.

b) A maximum of three children from birth to 12 months of age, and other children, for a maximum total of six children.

c) A maximum of six preschool children if all are older than 12 months of age.

d) A maximum of 10 children if no more than five are preschool age and of those five, no more than two are under 12 months of age.

STEPS TO OPEN A FAMILY CHILD CARE HOME

- Make an appointment with a licensing monitor, call in the North (305) 377-5494 or (305) 377-5509 in the South county area.
- Receive necessary forms and review procedure information.
- Opportunity for questions and answers.
- Complete background screening requirements.
- Fingerprints - federal criminal records check.
- Local criminal records check.
- Affidavit of Good Moral Character.
- Identify substitutes to complete training and screening requirements.
- Register for and complete Family Child Care Training Course.
- Schedule pre-licensing home visit with licensing monitor.
- Contact City Hall for your municipality or unincorporated Dade.
- Zoning Certificate of Use and Occupancy.
- Occupational License.

LICENSING GUIDELINES

BACKGROUND SCREENING

Complete screening is available through the Department of Children and Families Child Care Licensing office. The processing fee is $32 per person payable to FDLE by money order only. Children over the age of 12 years shall be screened for delinquency records.

Fingerprinting may be obtained at local police departments for an additional fee. Usually $10 is the standard fee.

All screening papers must be processed through the Child Care Licensing Unit and are required for operator, substitute, and all other adults who are living in the household.

Two (2) notarized character references for adults living in the household and for the substitute are also required.

Employment history for the last two (2) years.

HEALTH

All operators and adults living in the home must be screened for tuberculosis (TB) every two (2) years.

The operator and all household members must provide evidence of freedom from communicable diseases at the time of licensure.

TRAINING

The Department of Children & Families 30-Hour training course for Family Child Care Operators **must** be completed before being licensing. Contact the Department of Children and Families Child Care Training office at (305) 237-0936 or a vocational training facility in your area for information.

Additional training is required in the area of **First Aid** and **Infant/Toddler CPR**. Contact the Red Cross, vocational training facility or resource and referral agency in your area for class availability.

An American Red Cross Emergency Water Safety Certificate is required for any family child care home with a swimming pool over three feet in depth used by the children in care.

Annual 8 (eight) hour in-service training is required for providers with subsidized children in their care and strongly suggested for all family child care providers.

PHYSICAL FACILITY

The home must be clean and safe. Areas accessible to children must be free of toxic substances and rodents.

Firearms must be stored, locked, and unloaded.

There must be a working telephone on the premises.

Electric outlets must have safety plugs.

There shall be adequate, adjacent outdoor space on the premises. Playground equipment shall be safely installed. Concrete, asphalt, gravel, and other non-yielding substances are prohibited beneath any piece of permanently installed playground equipment.

Homes must have a fire extinguisher, (2A-10-BC), which is serviced annually by a licensed fire extinguisher company and at least one (1) wired in smoke detector with battery back-up. You must have two (2) exits, one not being the kitchen door. Check with the Fire Safety Department for more specific requirements for correct placement of equipment. This department is required to inspect a home before a license can be issued.

Homes must have adequate lighting, ventilation, a safe source of heat, and maintain a temperature between 65 F and 85 F.

Pools, canals, and water hazards **must be fenced.**

A first aid kit must be maintained in a designated location with soap, bandages, cotton balls, cotton swabs, gauze pads, adhesive tape, band-aids, thermometer, tweezers, and scissors. A First Aid Manual shall be accessible. Latex gloves are suggested to be included in the First Aid Kit. Universal precautions should be observed.

A diaper pail with secure lid and a potty seat must be available if necessary to meet the needs of the children in care.

Step-up platforms for easy access to sinks and toilets are suggested.

During naptime, infants, birth through the age of twelve (12) months must be in cribs or playpens with sides.

Each child shall have a separate bed, cot, crib, playpen or floor mat. Floor mats shall be at least one (1) inch thick.

Appropriate indoor, outdoor toys and equipment are required and must be maintained in good repair.

RECORD KEEPING

- **OPERATOR'S FILE**
  - Background screening information
  - Child abuse and neglect training statement
  - Family health records
  - Records of immunization for pets
  - Training certificates
  - Written instructions for emergency/substitute

- **CHILDREN'S FILES**
  - Enrollment forms (CF-FSP form 5012 or equivalent)
  - Children's Immunization Record (DH form 680)
  - Student Physical Examination (HRS-H form 3040)
  - An authorization for Medication form to be completed as necessary and kept on file for four (4) months
  - Disciplinary practices signed by parent
  - Family Child Care brochure statement signed by parent
  - Accident/Incident reports as appropriate

GENERAL INFORMATION

TRANSPORTATION

If transportation is provided, drivers and vehicles must meet **all** state and county requirements. Child Restraint Car Seat or Carrier Device must be used for children under 4 years of age. Seat belts are required for all individuals. Infants and small children should never be in the front seat.

INSURANCE

Liability and accident insurance is not required to operate a family child care home. If you provide contracted services for subsidized child care you may be required to purchase commercial liability coverage. A homeowner's insurance policy without a special rider does **not** cover the family child care operation and they may require you to purchase a separate commercial liability policy in order to maintain your homeowner's coverage. Seek advice from a reputable source.

BUSINESS RECORDS AND EXPENSES

Family Child Care is a nationally recognized profession that has certain year long requirements in order to file adequate records with IRS. The local chapter of the Florida Family Child Care Home Association, Inc. is a good source for current information. Call (954) 581-1192 for the contact person in your area.

START UP COST WORKSHEET

	(Per person)		(number of people)		(Total)
Background screening fee	________	x	________	=	________
Fingerprints	________	x	________	=	________
Physical Examination	________	x	________	=	________
Tuberculosis (TB) Test	________	x	________	=	________
FCC 30-hrTraining Course	________	x	________	=	________

Fire Extinguisher = ________

Wired in smoke detector(s) = ________

First aid kit / supplies / manual = ________

Toys and equipment = ________

Zoning Permit = ________

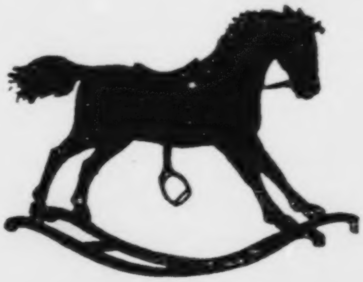
Occupational License = ________

Fire Inspection = ________

Fencing (if necessary) = ________

Liability Insurance = ________

GRAND TOTAL = ________



Family Child Care Ratio - Effective 1/1/97

Ratio clarification chart developed by Tammy Tener, Region 3 Provider for the
Florida Family Child Care Home Association, Inc.

Provider's own children (birth to 12 years) are included in the total count

Infants 0-12mths	Preschool 1 yr-5yrs	Schoolage 5yrs +	Total Children
4	0	0	4
3	3	0	6
3	2	1	6
3	1	2	6
3	0	3	6
2	4	0	6
1	5	0	6
0	6	0	6
2	3	5	10
2	3	5	10
2	1	7	10
2	0	8	10
1	4	5	10
1	3	6	10
1	2	7	10
1	0	9	10
0	5	5	10
0	4	6	10
0	3	7	10
0	2	8	10
0	1	9	10
0	0	10	10

A provider can meet a different category (a, b, c, or d - as listed on page 1) at different times of the day or week and is not limited to one category on the registration or license.

Your license will not reference any one group or number of children.
It is up to the provider to be in compliance **at all times**. There is **no** overlap, shift change or grace time allowed.

Family Central, Inc.
Resource & Referral
15910 NW 57 Avenue
Miami Lakes, FL 33014
305-908-5755

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FLORIDA CHILDREN'S FORUM

United Way

The Symbol of Quality COA ACCREDITED

309

MIAMI-DADE

FLORIDA DEPARTMENT OF CHILDREN & FAMILIES

Departamento de Niños y Familias
(Department of Children and Famililes)

Guías para obtener la Licencia de

Hogares de Cuidado Infantil

Estatuto 65C-20r

Cómo comenzar un Cuidado Infantil en el Hogar

Guía general

Desarrollada para el Condado de Miami-Dade por
Michele D. Scott, M.S.
Educadora Preescolar y Especialista en Hogares de Cuidado Infantil
Universidad de Miami, Mailman Centro de Desarrollo Infantil
(305) 322-6059

en colaboración con:
Departamento de Servicios Humanos de Miami-Dade,
Oficina de Desarrollo Humano
División de Servicios para el Desarrollo Infantil
(305) 633-6481

La Guias para obtener la licencia se basa en las regulaciones para los Hogares de Cuidado Infantil, establecidas por el Departamento de Niños y Familias del Estado de la Florida, Capítulo 65C-20, Estatutos 402.301-3195. Estas regulaciones son obligatorias en el condado de Miami-Dade.

¿QUIÉN DEBE OBTENER LA LICENCIA DE CUIDADO INFANTIL?

El condado no exige la licencia cuando se cuida solamente los niños de una familia y éstos no son parientes. Las regulaciones establecen número limitado de niños en los hogares de cuidado infantil.

Debe obtener la licencia de cuidado infantil la persona que cuida a niños de dos o más familias que no son sus parientes, cualquiera sea la forma de pago que recibe. Las regulaciones especifican cuatro tipos de grupos dependiendo de la cantidad de niños, las edades de los niños y adultos que los cuidan:

a. Un máximo de 4 niños de edades comprendidas desde recién nacidos hasta los 12 meses de edad.

b. Un máximo de 6 niños, con sólo 3 niños de edades comprendidas desde recién nacidos al año (12 meses) y los demás niños mayores de 12 meses.

c. Un máximo de 6 niños de edad preescolar, todos mayores de 1 año.

d. Un máximo de 10 niños, 5 niños de edad preescolar y solo 2 niños menores de 12 meses de edad.

Después de obtener la licencia para el cuidado infantil en el hogar específico a un grupo, podrá cambiar a otro sin necesidad de hacer de nuevo la solicitud.

PROCESO PARA OBTENER LA LICENCIA DE CUIDADO INFANTIL EN EL HOGAR

- ☐ Comuniquese con la Oficina de Licencias de Cuidado Infantil al (305) 377-5494 para el norte del Condado o al (305) 377-5509 para el sur y pida una cita.
  - Obtenga los formularios necesarios
  - Estudie la información sobre el proceso
  - Aproveche la oportunidad para obtener más información
- ☐ Complete los requisitos para la verificación de antecedentes penales:
  - Huellas digitales y verificación de los antecedentes penales federales
  - Verificación de los antecedentes penales con el departamento de policía local
  - Declaración de buena moral jurada, firmada y aprobada por un notario público.
- ☐ Presente la documentación de su substituto que recibirá entrenamiento y cumplirá con los requisitos de verificación de antecedentes
- ☐ Regístrese y complete las clases obligatorias para Hogares de Cuidado Infantil
- ☐ Establezca una fecha para que representantes de la Oficina de Licencias visiten y verifiquen el estado de su residencia.
- ☐ Comuniquese con la Alcaldía (*City Hall*) para localizar la municipalidad o las municipalidades no incorporada de Dade que le corresponde para obtener:
  - Los Certificados para Funcionamiento y Capacidad establecidos por la oficina de Zonificación

GUÍA PARA OBTENER LA LICENCIA DE CUIDADO INFANTIL

VERIFICACIÓN DE LOS ANTECEDENTES PENALES

La verificación de los antecedentes se obtiene y se procesan en la Oficina de Licencias de Cuidado Infantil del Departamento de Niños y Familias (Department of Children and Families Child Care Licensing Office) El costo por el trámite es de $32 por persona, pagaderos a **FDLE** con un Money Order. Tanto la persona principal que ofrece el cuidado infantil como los substitutos deben cumplir con este requisito. Jovenes de 12 años o mas deben ser verificados sobre records de delincuencia juvenil.

La verificación de las huellas digitales se realiza en el Departamento de Policía local, generalmente por un costo de $10.

También se exigen dos (2) referencias de la buena moral del substituto y de cada uno de los adultos que residen en el hogar, dichas referencias deben estar selladas por un notario público.

Historial de empleos de los últimos dos (2) años.

REQUISITOS MÉDICOS

Todas las personas que cuidan a los niños y los adultos que vivan en la casa deben someterse a la prueba de tuberculosis (TB) cada dos (2) años.

El proveedor del cuidado, el substituto y cada miembro de la familia que resida en el hogar deben suministrar prueba médica de que no tienen enfermedades contagiosas al solicitar la licencia.

CAPACITACIÓN PROFESIONAL

Las clases obligatorias para Hogar de Cuidado Infantil deben completarse antes de obtener la licencia. Para informarse de estas clases, llame al (305) 237-0936 a la Oficina de Entrenamientos del Departamento de Niños y la Familia (Department of Children and Families, Child Care Training) o a una institución de capacitación vocacional en su área.

Se exige además, las clases de Primeros Auxilios y Resucitación Cardiopulmonar. Para información acerca de estas clases, llame a la Cruz Roja, a una institución de capacitación vocaciónal o con una agencia de Recursos y Referidos en su área.

Para los solicitantes que tengan piscinas/albercas de más de tres pies (90 cm) de profundidad que los niños usarán con supervisión, se les exige el Certificado de Seguridad para Emergencias Acuáticas (*Emergency Water Safety Certificate*) de la Cruz Roja Norteamericana.

Las personas que cuidan niños del programa de subsidio están obligados a tomar 8 (ocho) horas de clases adicionales, cada año. Se le aconseja a todos los demás proveedores de cuidado infantil en el hogar, el asistir a dichas clases.

LA RESIDENCIA/CASA

La residencia debe ser segura y mantenerse limpia. Las áreas accesibles a los niños deben estar libres de substancias tóxicas y plagas (insectos, roedores, etc.)

Las armas de fuego deberán estar descargadas y guardadas en algún lugar bajo llave, fuera del alcance de los niños.

Debe tener un teléfono que funcione.

Todas las tomas de corriente eléctricas deben estar cubiertas.

Necesita una área exterior adyacente para el uso de los niños. El equipo para jugar debe ser estable. Están prohibidas las superficies de concreto, asfalto, grava o superficies duras, debajo y alrededor de los equipo de juego.

Debe tener un extinguidor de incendios, (2A-10-BC), que debe ser revisado anualmente por una compañía especializada en extinguidores. Debe contar, al menos con un (1) detector eléctrico de humo que funcione con pilas para cuando falte la electricidad. La residencia debe tener dos (2) salidas, una que no sea la salida de la cocina. El Departamento de Bomberos (*Fire Safety Department)* puede informarle sobre la colocación correcta de los muebles y artefactos eléctricos. Es necesario que el Departamento de Bomberos realice una inspección de la casa para obtener la licencia.

La residencia debe tener suficiente iluminación, ventilación y calefacción; la temperatura debe mantenerse entre 65° y 85° F (18° y 29° C)

Deben cercarse las piscinas/albercas, los canales y áreas que representen peligro para los niños.

Debe tener a mano un manual de primeros auxilios y un botiquín de primeros auxilios que mantendrá en un lugar accesible, con jabón, vendas, algodón en bolas y en bandas, almohadillas de gasa, esparadrapo, banditas, termómetro, pinzas y tijeras. Se aconseja incluir guantes de plástico/látex en el botiquín. Se deben tomar precauciones.

Debe contar con una cubeta para pañales provisto de tapa segura, y un retrete para los niños pequeños.

Se aconseja instalar peldaños/plataformas a los niños para facilitar el acceso a lavamanos y retretes.

Durante la siesta los niños, desde recién nacidos hasta la edad de doce (12) meses, deben usar cunas o corrales con barandas.

Cada niño debe tener su propia cama, catre, cuna, corral o colchoneta. Las colchonetas deben tener por lo menos una (1) pulgada de ancho (2.5 cm)

Se exigen juegos y equipos adecuados y en buenas condiciones, tanto para el interior como para el exterior.

DEBE MANTENER UN ARCHIVO DE:

- ☐ **DOCUMENTACIÓN ACERCA DEL PROVEEDOR**
  - Información de la verificación de los antecedentes penales
  - Certificación de entrenamiento sobre el abandono y la negligencia de menores
  - Historia Médica de su familia
  - Certificados de vacunas de los animales domésticos
  - Certificados de capacitación profesional
  - Instrucciones escritas para situaciones de emergencia y para el proveedor substituto

- ☐ **DOCUMENTACIÓN ACERCA DE LOS NIÑOS**
  - Formularios de inscripción/matriculación (CF-FSP formulario 5012 o equivalente)
  - Certificado de inmunizaciones de cada niño (DH formulario 680)
  - Examen médico del estudiante (HRS-H forma 3040)
  - Autorización de los padres para suministrar Medicamentos que deben firmar cuando sea necesario y mantenerse en archivo durante cuatro (4) meses
  - Explicación de procedimientos disciplinarios. Debe mantener una copia firmada por los padres aprobando los procedimientos disciplinarios que se practican
  - Declaración del folleto de Hogares de Cuidado Infantil firmado por uno de los padres, de cada niño.
  - Reporte de accidentes cuando sea necesario

INFORMACIÓN GENERAL

TRANSPORTE

Si ofrece transporte, los conductores y los vehículos deberán cumplir con todos los requisitos estatales y del condado. Los niños menores de 4 años de edad deben viajar en sillas y/o equipos adecuados. Todas los ocupantes del vehículo deben colocarse los cinturones de seguridad. Los bebés y niños pequeños nunca deben colocarse en el asiento delantero.

SEGURO/ASEGURANZA

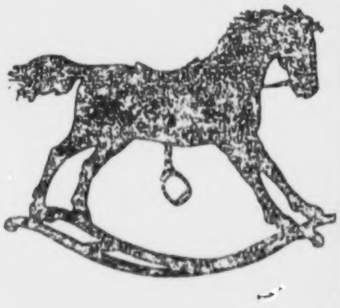
No se exige seguro de responsabilidad civil (*liability*), ni seguro contra accidentes para el funcionamiento de un hogar de cuidado infantil. Puede necesitar un seguro de responsabilidad civil comercial sí lo contratan para ofrecer cuidado infantil subsidiado. La póliza de seguro del propietario de la casa, sin una cláusula adicional, no cubre el funcionamiento del hogar de cuidado infantil. Tal vez la compañía de seguro como propietario le exija una póliza de responsabilidad civil comercial adicional. Solicite el consejo de un especialista.

ARCHIVOS Y GASTOS DE NEGOCIOS

El cuidado infantil en el hogar es una profesión reconocida nacionalmente, se deben cumplir ciertos requisitos durante todo el año con el fin de presentar al IRS la documentación necesaria. Si desea mayor información, puede comunicarse con la Asociación de Proveedores de Cuidado Infantil en el Hogar de la Florida, Inc., al (954) 581-1192, un representante de su área le ofrecerá información.

COSTO INICIAL

	(Por persona)		(número de personas)		(total)
Verificación de los antecedentes	__________	x	__________	=	__________
Huellas digitales	__________	x	__________	=	__________
Examen médico	__________	x	__________	=	__________
Prueba de tuberculosis (TB)	__________	x	__________	=	__________
Extinguidor de incendios				=	__________
Detector(es) de humo				=	__________
Botiquín de primeros auxilios, suministros y manual				=	__________
Juegos y equipos				=	__________
Permiso de la Oficina de Zonificación				=	__________
Licencia de Capacidad				=	__________
Inspección del Departamento de Bomberos				=	__________
Cercas (si es necesario)				=	__________
Seguro de Responsabilidad Civil (*liability*)				=	__________
TOTAL				=	__________



Número de niños por edades, establecidos para los Hogares de Cuidado Infantil- Efectivo el 1/1/97

Los hijos de la persona que ofrece el cuidado en edades comprendidas desde recién nacidos a los 12 años de edad se incluyen en el número total de niños:

Niños de 0 a 12 meses	Niños de 1 a 5 años	En edad escolar 5 años ó más	Total de niños Por adulto
4	0	0	1:4
3	3	0	1:6
3	2	1	1:6
3	1	2	1:6
3	0	3	1:6
2	4	0	1:6
1	5	0	1:6
0	6	0	1:6
2	3	5	1:10
2	2	6	1:10
2	1	7	1:10
2	0	8	1:10
1	4	5	1:10
1	3	6	1:10
1	2	7	1:10
1	1	8	1:10
1	0	9	1:10
0	5	5	1:10
0	4	6	1:10
0	3	7	1:10
0	2	8	1:10
0	1	9	1:10
0	0	10	1:10

Puede obtener la licencia de cuidado infantil en el hogar para cualquiera de los grupos (a, b, c ó d, listados en 1ra. página) pero no tiene que limitarse a solo un tipo, pues puede ofrecer cuidado durante diferentes horarios del día o de la semana.

La Licencia de Cuidado Infantil en el Hogar no especifica por escrito la cantidad o edades de los niños. La persona que ofrece el cuidado será responsable por cumplir con todas las normas. Si un hogar de cuidado infantil ofrece cuidado a diferentes grupos de niños debe evitar que se sobrepongan los turnos de los niños y/o los horarios

Family Central, Inc.
Resource & Referral
15910 NW 57 Avenue
Miami Lakes, Fl 33014
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CHILDREN
& FAMILIES

The Enterprise Zone-Preschool Inclusion Project

A Training and Resource Manual for Inclusion in Childcare

Book 2: Technical Assistance

U.S. DEPARTMENT OF EDUCATION
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EC 309364

A helpful tool for Early Care & Educational Professionals

The Enterprise Zone-Preschool Inclusion Project

A Training and Resource Manual for Inclusion in Childcare

University of Miami

School of Medicine
Mailman Center for Child Development
Miami, Florida

Susan Gold, Ed.D., Principal Investigator

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#H024B70071

The Enterprise Zone-Preschool Inclusion Project

Book 2
Technical Assistance Component

Book 2: TECHNICAL ASSISTANCE

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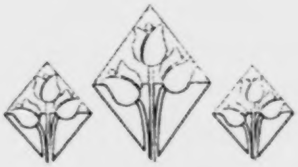

The Enterprise Zone-Preschool Inclusion Project

Special Instruction Consultant

Special Instruction Consultant

- **Description**

  The Role of the Special Instruction Consultant

  Difficulties to the Implementation of the SIC Model

- **Sample Case Studies**

- **List of Concerns and Strategies**

- **Children Medical Services (CMS) Special Instruction Consultant Standards**

Technical Assistance Component
Special Instruction Consultant

Description

The second component of the Enterprise Zone – Preschool Inclusion Project (EZ-PIP) was technical assistance. We adapted our state's Children's Medical Services (CMS) model of the Special Instruction Consultant Service to our project. The CMS guidelines are attached at the end of this section.

Technical assistance is often mentioned in model programs such as ours but the actual services provided vary considerably depending on the model. Our plan was to offer hands-on child specific information to the childcare staff. It was our feeling that the staff had been given adequate preparation regarding inclusion through the EZ-PIP training component but that they now needed individual assistance in including specific children with special needs in their childcare settings. They were willing to include children with disabilities but needed additional skills and information that were tailored to the individual child depending on the child's special needs. Therefore, one of the main objectives of the Special Instruction Consultant was to provide the classroom teachers with techniques to better serve a child who had a diagnosed disability, to assist teachers with children "on the waiting list" for an evaluation, and to make the staff feel more at ease in the classroom. In addition, Special Instruction Consultants helped teachers increase their knowledge and appreciation of children with special needs. Using the CMS guidelines as our model we asked that the Special Instruction Consultants provide assistance with the following:

- The design of the learning environment
- Activities that promote the child's acquisition of skills in a variety of developmental areas
- Curriculum planning, including the planned interaction of personnel, materials, time and space that leads to achieving the outcomes in the child's Family Support Plan (or Individualized Educational Plan) and the child's special instruction plan
- Providing agency staff and families with information and support related to enhancing the skill development of the child across different settings

The Role of The Special Instruction Consultant

Special Instruction Consultants act as a liaison between the center, the parent and other service providers. If a child needs an evaluation the

SIC can help the childcare center refer to the Early Intervention Program for children birth to thirty six months, or to Child Find for children over three. Childcare personnel are trained on how to proceed when there is a concern with a child. This procedure helps teachers identify children age birth to 5 who need to be evaluated and referred for outside services. Special Instruction Consultants coordinate services and provide follow-up assistance to children with disabilities at the participating childcare centers. Additionally, the SIC can bring therapists and/or other service providers and teachers together in order to include their goals into classroom routines and activities. These therapists can be instrumental in providing information on how to assist the child in the classroom. Once the staff becomes familiar with the referral process, feels comfortable coordinating service providers and implementing classroom adaptations and modifications, Special Instruction Consultants may no longer be needed at that particular center.

Special Instruction Consultants in the EZ-PIP project visited participating child-care centers based on their need. Each center received an EZ-PIP reference manual to help child care staff feel more at ease through the referral process as well as to learn where to find particular information about children with special needs. A copy of this reference manual is included at the end of this section and is divided into five parts consisting of:

1. Information about the project –EZ-PIP

2. Laws and regulations
3. Forms required for proper referral process such as parental consents in English, Spanish, and Creole
4. Community resources
5. Helpful information and online resources

Consultations were conducted with directors, teachers and parents to develop an action plan for the child in need. The Special Instruction Consultant provided technical assistance such as making suggestions for changing the learning environment, adapting activities, developing classroom strategies and curriculum planning. SIC's also provided guidance for integrating the goals of the Family Support Plan (FSP) or Individual Educational Plan (IEP) into classroom and home activities.

During the first contact the Special Instruction Consultant services were explained to the center director. All of the centers that were contacted had participated in the EZ-PIP training series so rapport had already been established. The Project Manager or the Special Instruction Consultant called or visited the centers to explain the services available. If the center director and teachers expressed interest in participation the SIC would arrange to come to the center. The SIC would ask the center director or staff whether there were concerns about particular children. If the center director or staff indicated that they had concerns about a specific child or children the SIC would give parent consent forms to the teacher to send to the parent (see attached). After the parent consent forms were signed and sent back to the center the SIC would arrange a meeting between the classroom teacher, the parent, herself, and the director. The SICs also met with the staff to discuss specific children who did not yet have a diagnosed disability. In these cases, if it appeared that there was a potential delay or other special need, the SIC would assist the staff in making the appropriate referrals for evaluation. Once the center expressed a need, the Special Instruction Consultant would visit the childcare center regularly (once or twice a week). The steps for this process are listed below in detail:

1. Project Manager introduces SIC, explains what an SIC does and how she/he can help child care staff
2. Special Instruction Consultant asks about children in teacher's classrooms. Do they have any children with a diagnosed disability? Do they have concerns about any children in their classrooms? Are any children receiving outside services? A form was distributed for teachers to record this information (see attached).
3. Distribute parent consent/denial of consent form. Explain why it is necessary to have parent consent prior to providing services. Parent meetings are strongly encouraged and can be scheduled with the Special Instruction Consultant, director and teacher to answer any questions and explain the referral process.
4. Refer the child for an evaluation if this has not already occurred. The SIC should be available to follow-up on the referral process

and provide interim suggestions for including the child in the childcare setting.

5. If the child has already received an evaluation develop an action plan to address the goals listed on the FSP or IEP. An action plan consists of developing objectives and specific classroom strategies to assist the child in reaching the goals stated on the FSP or IEP.
6. The SIC will serve as a liaison between childcare programs and community service agencies. This may include contacting other members of the FSP or IEP team to discuss how the goals can be integrated, arranging for therapists to come to the childcare setting, and attending FSP or IEP annual updates.

Difficulties to the Implementation of the SIC Model

While this model had been developed for some time in the state of Florida there were some challenges in its implementation. One of the biggest difficulties was finding qualified personnel to serve as Special Instruction Consultants. Children's Medical Services requires a SIC to have a minimum of a Bachelor's degree in Early Childhood Education, Child Development, Early Childhood Special Education, Special Education or an equivalent degree. Additionally the SIC should have a minimum of 3 years clinical or classroom experience working with children who are typically developing and children who have special needs, and 2 years of supervisory or administrative experience (see attached CMS guidelines).

We had some difficulty-identifying individuals with this amount of training and experience who were still sensitive to the needs of the childcare staff. We reduced the educational requirements in the second year of our project and had successful experiences with two individuals who had not yet completed their degrees. Finding the appropriate staff to serve, as SICs is crucial to having a successful technical assistance component. Ideally, SICs would fulfill all of the requirements listed in the CMS guidelines. However, the relationships that the SICs form with the teachers must be built on mutual respect and trust. We also recommend that SICs receive an orientation of some type that would assist them in establishing rapport with the childcare staff. Perhaps attending some of the mentor training modules would be helpful. We found that some SICs were more successful than others at establishing relationships and some teachers were better able to receive the special assistance offered by the SICs than others. While there are innate abilities involved in establishing relationships, there are certain skills that can be learned by prospective SICs. Communicating respectfully with childcare staff, using active listening, being a careful observer in the classroom and maintaining a flexible attitude are all important skills for SICs to have.

Another challenge faced by the project was finding Special Instruction Consultants who fully embraced the philosophy of inclusion. Many people who have been trained in Early Childhood are not familiar with disabilities and many people who have been trained specifically to work in special education settings are more comfortable with a segregated settings model. We did not require the Special Instruction Consultants to attend any of the EZ-PIP training sessions but suggest for future projects that the SICs should participate in the *Introduction to the Philosophy of Inclusion* module and the session on *Working Together.* These sessions would better prepare SICs to work in typical early childhood settings and help them to understand the unique challenges that childcare teachers face. It may be helpful for people who want to become SICs to pair up with existing SICs so that they can observe the methods that work best in classroom settings. SICs should be aware that some teachers will be more receptive than others and that some settings may not be appropriate for certain children. More information regarding these issues is presented in the following case studies.

Sample Case Studies

Case study #1

A successful example of inclusion using the Special Instruction Consultant model (note: names and locations have been changed to protect the anonymity of all parties involved).

Andrew was a 2-year-old child enrolled at a faith based childcare center. Most of the staff had completed the EZ-PIP training series. Andrew had a congenital heart defect and was moderately hearing impaired. He wore hearing aids and his family did not want him to learn *sign language. They wanted him to learn to use oral speech in order to communicate. Andrew's mother, the classroom teacher and the director at the childcare center were all concerned that his communication skills were lagging behind. As he got older the other children in his class were all talking but he was not. Additionally his mother was concerned about Andrew's behavior problems; specifically tantrums in which he would hold his breath until he passed out. The EZ-PIP project director set up a meeting between the SIC, the mother, the director and the teacher. The SIC had experience working in inclusive settings and had worked specifically with hearing impaired children for eight years. The first meeting was held at the childcare center director's office and included an overview of Andrew's development, a review of his Family Support Plan and the goals that were listed on it, and a subsequent observation of Andrew in the classroom.*

After the initial meeting the SIC observed Andrew in his classroom. The mother was present during the observation and shared her concerns with the SIC as they arose. The classroom was small in size but only 8 children were enrolled. There was one classroom teacher and occasionally an assistant would come in to provide bathroom breaks or to help with specific projects. The tone of the classroom was busy but controlled and the only excessive noise was generated by a room air conditioner. Andrew played with the other children, but was having difficulty with redirection and would tantrum when told that he could not *have something. Usually the mother and teacher would give in to his wishes, as they were fearful that he would pass out if he had a tantrum and held his breath. This was a legitimate concern as he also had a heart defect and had heart surgery.*

When the observation was over the SIC asked the mother to call Andrew's physician to ask if passing out would harm him. The doctor told her that as long as he did not bump his head when falling he would be okay. The SIC then developed a behavior management plan with Andrew's teacher and mother that involved setting limits on his behavior and ignoring his tantrums. His safety was always considered and when had a tantrum he was put in a safe area with cushioned mats and no hard objects that could hurt him if he fell. He soon stopped having tantrums, as there was no reward for them.

The second concern that the SIC addressed was that Andrew was falling behind in his communication skills. Since the family did not want Andrew to use sign language, the SIC developed some alternative communication methods to use with him. The teacher was working on having the children learn to identify farm animals. The SIC demonstrated how to use a large communication chart with Andrew during circle time and other focused language times during the day. Using poster board the SIC assisted the classroom teacher in identifying six farm animals, gluing magazine photographs of the animals on the board, printing the names of the animals under the photographs and covering the board with clear *contact paper. All the children in the class enjoyed using the chart and Andrew had a visual depiction of what the class was talking about. The SIC also suggested using other objects like toy farm animals, puzzles, and farm animal puppets. These methods were helpful for all the children in the class, not just Andrew. Additionally, the SIC demonstrated how to reinforce Andrew's oral language skills by making sure that he could see her face clearly when she spoke to him, breaking the communication into smaller parts, having him repeat what she said and assuring that his hearing aids were working correctly.*

The SIC worked with Andrew's teacher for approximately 10 ✓ *months. After the initial meeting with the mother, teacher and director she observed him in the classroom and then came to the classroom for about 1 hour each week. She maintained contact with the mother through communication with the teacher and through phone calls. Additionally, the mother volunteered in the classroom and was available to discuss Andrew's progress and any additional concerns that developed.*

Andrew was successfully included until he turned 3 ½ years old. At this time his mother and the rest of the team realized that even with support his language was still lagging behind the other children and he was becoming more frustrated. He had transitioned to the 3-year-old classroom and had a larger group of children with higher-level language skills to contend with. His speech therapist, mother, and the teacher in the 3-year-old classroom determined that the program was no longer meeting *his needs and he was transferred to a setting for children with hearing impairments. Although Andrew's inclusive childcare experience ended, he and his family had the benefit of having him enrolled in an inclusive setting for 1 year. His family, teacher, and classmates all benefited as much as Andrew did from his inclusion in the early childcare setting.*

Case study #2

An unsuccessful example of inclusion using the Special Instruction Consultant model (note: names and location have been changed to protect the anonymity of all parties involved)

David was a 2-½ year old boy enrolled at a corporate childcare center. His parents were divorced and did not communicate with one another although they shared custody. The childcare center's director resigned shortly after the initial meeting between the mother, the SIC and the director. The classroom teacher was not involved in the initial meeting and was not aware of the role of the SIC when she came for initial observation. The assistant director became the interim director and was having difficulty balancing her responsibilities.

David's classroom was very large in size and had a large group of children (24). Although the child/adult ratios were adequate (8:1) the classroom often seemed chaotic, loud and disorganized. This added to the difficulty that David was having. His Family Support Plan listed behavioral problems, speech delay and cognitive delay as areas of *concern. However, David was not receiving any therapy in the classroom setting because it was unavailable. Nor was he receiving outpatient therapy at clinic setting because his mother and father worked and could not transport him to therapy during the day.*

During the initial meeting David's mother stated that her biggest concern was that David would not follow directions and only wanted to watch the television show "Barney" at home. The director stated that the teachers were concerned that David did not pay attention, did not participate in classroom activities, was disruptive and aggressive and did not communicate. The team decided on the following goals for David: increase his ability to follow directions, increase his ability to communicate and decrease his aggressive behavior. The goals were broken into smaller objectives and the SIC suggested some specific strategies that could be implemented with David at home and in the classroom. She suggested using the television show "Barney" and books or toys depicting "Barney" to reinforce David's positive behavior. She also suggested that since David had language delays that it was important to present directions to him in a very simple way and to make sure that he understood what was expected of him. She left copies of the initial action plan with David's mother, one for the director to give to the teacher and one for David's father who would be picking him up from the childcare center that afternoon. The SIC arranged to come back later in the week to *observe David in the classroom setting and to make further suggestions at that time.*

When the SIC came back to observe David she met the new interim director who was unfamiliar with the SIC service. After explaining the service she asked if David's teachers had been given the action plan. They had not and it was never determined if David's father received the plan that had been left for him. The SIC went into the classroom and was met with a somewhat chaotic scene. The noise level was very high, the children were finishing snack and David had just dumped his juice on the table and was being reprimanded by a new teacher. The SIC attempted to introduce herself and explain what her purpose was in visiting the classroom. It quickly became apparent that what the teachers wanted most from the SIC was for her to take David out of the classroom to provide them with a break.

During subsequent visits the SIC was introduced to a variety of new teachers in the classroom. Turnover was high and the overall tone of the center was stressed and harried. David's behavior was unmanageable in the classroom and he often stripped off his clothes when outside and climbed into the water table. David's teachers would ask the SIC to take him out of the room as soon as she arrived and did not appear to understand that her role was to assist them in including David in regular classroom activities. While the SIC would make suggestions and bring activities with her that David enjoyed doing the teachers did not seem to *have the time or the interest to implement the strategies. The last straw was an incident in which David climbed over the playground fence and ran across a busy street. David was transitioned to a segregated setting for young children with disabilities.*

This was a disappointing experience for the SIC, for David's mother and it is presumed for the teachers and the director at the center. It reinforced the importance of having an informed and supportive director, dedicated and consistent staff, and an involved family. While David's family's experience with inclusion was not successful, it is hoped that in the future he will receive the supports he needs to be included with typically developing children.

List of Concerns and Strategies

Two of the Special Instruction Consultants who worked on this project developed a list of concerns and how they addressed these concerns. This information is provided in the following Table 2.1.

Table 2.1

Concerns	Strategies
◆ Some teachers felt that they needed more strategies at their disposal.	The teachers were given resources and strategies that were individually tailored to the child's special needs.

Table 2.1

Concerns	Strategies
◆ Teachers and center directors felt it would be beneficial if they knew that they had more options for referring the students they had concerns for.	The centers received resource manuals that contained agencies and providers that they could refer their students to.
◆ Some teachers were not sure as to what steps to take when there was a student they were concerned about.	The teachers were taken step by step through the referral process and the resource manual included referral forms.
◆ Some teachers felt that parents could have been more cooperative.	The SICs arranged to have parents present at initial meetings and to include them in developing plans for the child's inclusion
◆ Many teachers were concerned about behavior issues	SICs provided and modeled specific strategies for dealing with behavior problems.
◆ Teachers felt that there was too much paper work.	Teachers were made aware of the importance of screening, referral and evaluation and were assisted in implementing the steps.
◆ Some parents were afraid to sign consent forms for fear of labeling their children.	SICs had meetings with parents to explain services and to allay fears regarding labeling. Parents' fears were respected. Children who did not have a formal evaluation and action plan still benefited from having the SIC come to the classroom as her recommendations could be applied to all children.
◆ There were some parents whose primary language was not English	Every attempt was made to provide a Special Instruction Consultant who spoke the same language as the family. However, this was not always possible

Table 2.1	
Concerns	**Strategies**
♦ Some centers were not in compliance with regulations, therefore the staff felt threatened when the SIC came to the center.	While SICs made suggestions for improvements, their role was not to enforce compliance with regulation. SICs reminded the staff that the University of Miami, not a state or local licensing agency, employed them.
♦ Teachers wanted SICs to take "problem children" out of their classroom to work with them.	The SICs would occasionally take a child out of the classroom for part of the visit but would then give suggestions and strategies to the teacher for including the child in the classroom. The SICs also modeled how to interact appropriately with the child.

CMS EARLY INTERVENTION PROGRAM

SPECIAL INSTRUCTION CONSULTANT SERVICE

STANDARDS

Special Instruction Consultant Service

Service Description

Special Instruction Consultant Service is a service which is provided in typical child care settings by individuals with expertise in the area of special instruction and curriculum development for infants and toddlers with special needs for child care agency staff where children with established conditions and/or developmental delays are being served. The Special Instruction Consultant Service includes the provision of information by the consultant to agency staff in the following areas:

the design of learning environments;
activities that promote the child's acquisition of skills in a variety of developmental areas;
curriculum planning, including the planned interaction of personnel, materials and time and space that leads to achieving the outcome in the child's Family Support Plan and the child's special instruction plan; and
providing agency staff and families with information and support related to enhancing the skill development of the child both within the child care and other settings.

The Special Instruction Consultant service is intended to be provided in those situations when the family chooses to have their child cared for in a typical child care setting and the child care agency staff need support and/or more information in order to be comfortable in having the infants/toddler participate in the child care program. The determination of the need for this service will be a mutual decision of the Family Support Plan team, the Special Instruction Consultant, and the child care agency. The special instruction service will be provide only as long as the child care staff continue to require additional s[illegible]n and/or information. This service is not intended to be routinely recommended whenever an infant or toddler is served [illegible]ypical child care setting

This service may be funded by the CMS/Early Intervention Program for infants and toddlers served under the auspices of the CMS/Early Intervention Program who are eligible for the Part H component of the program and for whom this service has been authorized through the Family Support Plan process

Special Instruction Consultant Plan Development Service

The Special Instruction Consultant will develop an individual special instruction plan that is consistent with the Family Support Plan within one week of the child's placement in a cooperating child care agency. The individual special instruction plan is developed jointly by the classroom teacher(s), the family, the Special Instruction Consultant and others involved in the provision of services for the child (e.g., therapists). The special instruction plan addresses the needs of the child and the specific activities which will be used during the child's participation in the child care program which are needed to promote skills acquisition.

Special Instruction Cooperating Agency Participation Agreement

The Child Care Facility listed below agrees to:

1. Maintain a current HRS Child Care license according to F.A.C. 10M-12 (licensed, registered, or exempt facilities).

2. Arrange time for staff to work with the Special Instruction Consultant

3. Implement special instruction program plans developed with the Special Instruction Consultant for children with special needs.

4. Participate in an annual satisfaction survey of the staff and the families of infants and toddlers enrolled in the Special Instruction consultant services.

5. Allow therapists and/or early intervention providers to work with infants and toddlers in the child care facility, when specified on the child's Family Support Plan.

6. Provide information and participate in the Family Support Planning process for infants and toddlers served in the child care facility.

7. Participate in the local interagency council and other interagency coordination efforts. Participation may include participation at meetings, subscribing/reading minutes from such meetings, reviewing issues to be presented to such groups, and providing input into planning processes.

8. Have a written policy on the confidentiality of the records of staff and children that ensures that the facility will not disclose material child and personnel records without written consent from the parent/guardian and will adhere to procedural safeguard requirements for the CMS Early Intervention Program

9. Implement an individual special instruction plan that is consistent with the Family Support Plan. The initial plan is developed jointly by the classroom teacher, the family, the Special Instruction Consultant and others involved in the provision of services for the child (e.g., therapists). The plan addresses the needs of the child and the specific activities to address those needs which will be used during the child's participation in the child care program. Updates of the individual special instruction plan are developed with input from the individuals identified in the initial plan.

The Child Care agency agrees to participate in the provision of Special Instruction Consultant services for infants and toddlers served through the CMS Early Intervention Program. The agency understands that the CMS Early Intervention Program is not responsible for child care costs. Funding will be provided to the child care agency based on the Special Instruction Cooperating Agency service rate for each child for whom this service has been authorized on the child's Family Support Plan.

This agreement will be in effect from the date signed until terminated by the child care agency or the CMS EI Program.

Name of Child Care Agency: ______________________________

Name of Agency Owner/Director: ______________________________

Signature of Agency Owner/Director: ______________________________

Date: ______________________________

12/1/95

Special Instruction Consultant Service

Reimbursement

The reimbursement rate for this service was costed by Florida Taxwatch, Inc., based on the service standards. The same cost information was used to develop the rates for the center-based day program service. Based on the analysis conducted by Taxwatch the following payment rates will be used for the Special Instruction services:

Special Instruction Consultation	$15 per unit, where a unit is 1/2 hour may include up to 1 hours travel time period visit per location
Special Instruction Consultation Plan Service	$90 per service
Special Instruction Cooperating Agency Service	$7.50 per unit, where a unit is 1/2 hour

ice Requirements and Limitations

Special Instruction Consultant Plan Development Service -

Special Instruction Consultant Plan Development Services may be provided not more than once every three months.

Special Instruction Consultant Service -

Special Instruction Consultant Services must consist of at least a 30 minute of face-to-face contact (per child per month) between the Consultant and child care agency staff, the child's parents/family, or other caregivers/providers.
The maximum amount of time that will be reimbursed by the CMS/EI Program for face-to-face contact will be 3 hours per week per child for the first month that the service is provided. Thereafter, a maximum of 1 hour per week per child will be paid.
Actual travel time may be reimbursed up to a maximum of 60 minutes for round-trip travel time per day per facility/location.
This service is paid on an hourly basis, based on the amount of time (number of hours) the Special Instruction Consultant works in the cooperating child care agency (plus travel time). The service will be billed based on quarter hour increments.

Special Instruction Cooperative Agency Service -

The child care agency where an eligible child is being served will be reimbursed for this service for each authorized child served by the agency.
Special Instruction Cooperating Agency Services must consist of at least 30 minutes of face-to-face contact (per child per month) between cooperating child care agency staff and the Special Instruction Consultant.
The maximum amount of time that will be reimbursed by the CMS/EI Program for face-to-face contact will be 3 hours per week per child for the first month that the service is provided. Thereafter, a maximum of 1 hour per week per child will be paid.
This service is paid on an hourly basis, based on the amount of time (number of hours) the Special Instruction Consultant works in the agency. The service will be billed based on quarter hour increments.

Special Instruction Cooperating Agency Service

Each child care/family child care agency which participates in the provision of this service will sign the Participation Agreement with the CMS Early Intervention Program.

2. The child care/family child care agency which participates in the provision of this service will meet the following standards:

   A. Maintain a current HRS Child Care license according to F.A.C. 10M-12 (licensed, registered or exempt facilities).

   B. Arrange time for staff to work with the Special Instruction Consultant

   C. Implement special instruction program plans developed with the Special Instruction Consultant for children with special needs.

   D. Participate in an annual satisfaction survey of the staff and the families of infants and toddlers enrolled in the Special Instruction consultant services.

   E. Allow therapists and/or early intervention providers to work with infants and toddlers in the child care facility, when specified on the child's Family Support Plan.

   F. Provide information and participate in the Family Support Planning process for infants and toddlers served in the child care facility.

   G. Participate in the local interagency council and other interagency coordination efforts. Participation may include participation at meetings, subscribing/reading minutes from such meetings, reviewing issues to be presented to such groups, and providing input into planning processes.

   H. Have a written policy on the confidentiality of the records of staff and children that ensures that the facility will not disclose material related to child and personnel records without written consent of the parent/guardian and will adhere to procedural safeguard requirements for the CMS Early Intervention Program.

   I. Implement an individual special instruction plan that is consistent with the Family Support Plan. The initial individual special instruction plan is developed jointly by the classroom teacher, the family, the Special Instruction Consultant and others involved in the provision of services for the child (e.g., therapists). The special instruction plan addresses the needs of the child and the specific activities to address those needs which will be used during the child's participation in the child care program. Updates of the individual special instruction plan are developed with input from the individuals identified in the initial plan.

10. The consultant will assist the family and primary service coordinator in monitoring the child's development and in developing a complementary home program, as requested. The Special Instruction Consultant may provide EI consultation services when coordinating the implementation of a complementary home program with an early intervention home visiting provider or similar provider. The time that the consultant spends in this activity is included in the maximum amount of time during the first month and thereafter for which the EI program will pay

11. The consultant will conduct an ongoing functional assessment of each assigned infant and toddler in relation to the need for special instruction consultant services. This information will be available for the ongoing Family Support Plan process.

12. As a general guideline, the Special Instruction Consultant will serve not more than 15 infants and toddlers at one time Actual caseload assignments will be based on the needs of each assigned child and the number and needs of the child care agencies to which the consultant provides services.

13. The Special Instruction Consultant will participate in an annual satisfaction survey of the staff and the families of infants and toddlers enrolled in the Special Instruction Consultant Services.

Agreement to Provide Services as a Special Instruction Consultant for Dade County EIP

The below named applicant has met the educational and experience requirements to participate as a Special Instruction Consultant as described by the State Children's Medical Services Early Intervention Program Unit.

This agreement is in effect from the date signed until terminated by either the SIC Consultant or the Early Intervention Program.

I agree to participate as a Special Instruction Consultant according to the guidelines developed by the State CMS EI Unit as described herein.

Name of SIC Consultant Applicant: ______________________________

Signature of SIC Consultant: ______________________________

Name of Associate Agency: ______________________________

Date: ______________________________

Special Instruction Consultant Service

1 The individual who serves as the Special Instruction Consultant will meet the following education and experience requirements.

A. Bachelor's degree or higher in one of the following areas: Early Childhood, Child Development, Early Childhood Special Education, Special Education, or an equivalent degree based on transcript review, and

B. at least 3 years clinical/classroom experience (combined) working with typical and special needs prekindergarten populations and 2 years of supervisory/administrative experience; or 5 years clinical/classroom experience (combined) working with typical and special needs prekindergarten populations.

C. A Master's degree in one of the above areas may be substituted for one (1) year of the required experience; a Doctorate degree in one of the above areas may be substituted for two (2) years of the required experience

2 The provider of this service may be an individual practitioner or an individual who is employed by an agency that agrees to participate in the provision of this service If the provider is an individual practitioner the individual will enter into a service provision agreement with the CMS EI Program which will at a minimum specify that the EI Program will provide oversight for the independent practitioner.

3 The Special Instruction Consultant agrees to provide special instruction consultant services to infants and toddlers served through the CMS Early Intervention Program for whom this service is authorized through the Family Support Plan process

4 The Special Instruction Consultant will work with child care agency staff to develop an individual special instruction plan within one week of the child's placement in a cooperating child care agency. The individual special instruction plan is developed jointly by the classroom teacher, the family the Special Instruction Consultant and others involved in the provision of services for the child (e.g., therapists) Collateral information available from the Family Support Plan and evaluation processes and the outcomes and activities identified on the child's Family Support Plan are used to develop the individual special instruction plan for a child The special instruction plan addresses the needs of the child and the specific activities which will be used during the child's participation in the child care program which are needed to promote skills acquisition

5 The Special Instruction Consultant will work with child care agency staff to enhance staff knowledge of strategies to implement special instruction plans, to identify special needs of children cared for, and to increase the general knowledge of staff of factors related to the growth and development of infants and toddlers with established conditions and/or developmental disabilities. This may include one-on-one work with individual child care agency staff, the provision of in-service training sessions for child care agency staff, and the provision of resource materials.

6 The Special Instruction Consultant will provide data on services provided to infants and toddlers required by the CMS Early Intervention Program. The service data will be provided on at least a calendar month basis.

7 The Special Instruction Consultant will maintain regular, ongoing contact with the child care agency staff where infants and toddlers assigned to the consultant are being served. Contact may be more involved during the first several weeks of a child's initial placement in a cooperating child care agency and may be reduced, as appropriate, thereafter. Consultant contact with child care agency staff will consist of at least one monthly contact for the duration of the provision of this service.

8 The child's Family Support Plan team will review the provision of special instruction consultant services every six (6) months after initial placement to determine the ongoing need for this service.

9 The consultant will coordinate with the Family Support Plan team, the family, the classroom teacher, and others as appropriate to develop, for each infant or toddler, goals and assist in implementing strategies to accomplish those goals within the curriculum used by the child care agency.

The Enterprise Zone-Preschool Inclusion Project

Technical Assistance Resource Manual

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Law & Regulations: **IDEA '97 Law & Regs**

IDEA '97 FINAL REGULATIONS AN OVERVIEW

The Individuals with Disabilities Education Act Amendments of 1997, enacted on a strong bipartisan basis, significantly improved the educational opportunities for children with disabilities. The IDEA Ì97 focuses on teaching and learning, and established high expectations for disabled children to achieve real educational results.

The focus of IDEA changed from one that merely provided disabled children access to an education to one that improves results for all children in our education system. The IDEA '97 strengthens the role of parents in educational planning and decision making on behalf of their children. It focuses the studentÌs educational planning process on promoting meaningful access to the general curriculum. The new law also reduces the burden of unnecessary paperwork for teachers and school administrators. All of this was accomplished without compromising the Clinton/Gore AdministrationÌs fundamental principle of protecting the basic rights of children with disabilities to a free appropriate public education.

In October of 1997, the Department of Education published proposed regulations that drew nearly 6,000 comments from across the educational and political spectrums. After careful consideration, the Department has made various changes to nearly 60 percent of the sections included in the proposed rules.

The Department of Education has prepared a user-friendly package of final regulations designed to help parents, teachers and school administrators understand the federal expectations for educating children with disabilities, as set forth in the law. The package of regulations merely reflects the good changes made by Congress in the IDEA '97. The final IDEA Ì97 regulations appear in the March 12th *Federal Register*.

- The actual text of the regulations only comprise a quarter of the package, and includes the text of the statute;

- Two-thirds of the package is the Departmentìs analysis of the nearly 6000 comments and other required items; and,
- Technical assistance documents make up the remainder of the package.

The Department concluded that neither the statutory requirements nor the non-statutory requirements of these regulations have a major cost impact on school districts. However, because several provisions, when looked at individually, do have a major impact on schools, the Office of Management and Budget determined that the regulation has been designated as a major rule. For example, the Department estimates that school districts will realize savings in excess of $100 million from changes made by the IDEA '97 that eliminate unnecessary evaluations, every three years, to determine whether a child still has a disability. However, these and other savings would be offset by increased costs associated with such changes as the requirement for the regular education teacher to participate in IEP meetings.

As a whole, these regulations merely interpret the many changes Congress made in the law with the IDEA Amendments of 1997. This regulatory package offers some very needed federal assistance to those working to improve educational results for all children.

The Department of Education will provide specific and ongoing technical assistance. For the next few months, those technical assistance efforts will be specific to the statute and accompanying regulations. Ongoing technical assistance activities will incorporate specific and appropriate research-based practices that work. Immediate technical assistance plans include:

- **National Satellite Teleconferences**: The Department of Education, in collaboration with four IDEA Partnership Projects, will present national satellite telecasts on March 3rd and March 18th. Designed to help parents and practitioners in states, districts, and local schools, this series of two teleconferences will address key issues surrounding effective implementation of the IDEA '97.
- **Workshops:** The Department of Education is sponsoring six regional workshops on the IDEA '97. They are scheduled through April and will be hosted by the Regional Resource Centers. The workshops will provide accurate, up-to-date information regarding the statutory provisions of the IDEA Ì97 and the final regulations implementing the statutory provisions. These workshops will be interactive and offer a full discussion of the changes made from proposed to final regulations. The audience for these workshops has been carefully determined. Invitees will include State Directors of Special Education and members of their staffs, Directors of Parent Training and Information Centers and members of their staffs, State Hearing Officers and mediators, State Advisory Panel

members, Independent Living Center representatives, the Secretary's Regional Representatives, Technical Assistance Providers, members of the State Implementation and Monitoring Committees and other invited participants.

- **Additional Activities:** In addition to the teleconferences and technical assistance workshops mentioned above, OSERS is planning a wide range of other dissemination and training activities. These activities will be designed to bring information about IDEA '97 changes to the grass roots level, and provide examples of how research-based best practices can be used to help effectively implement the law. OSERS will use state of the art technology to reach principals, special education administrators, and parents.

The Department recently funded four "IDEA Partnership Projects" with the intent of developing statutory and regulatory expertise among our key partners. These Projects focus on policymakers, local administrators, service providers and educators, and families and advocates. The Department will enlist these partnership projects in further information dissemination and technical assistance activities.

For further information about the IDEA Ì97 statute and implementing regulations, contact the Department of Education at 202-205-5465 or 202-205-5507, or visit the DepartmentÌs website at http://www.ed.gov/offices/OSERS/Policy/IDEA/.

This document was prepared by OSEP. It has been formatted by Education Development Center, Inc, for the IDEA Practices web site, a service of the OSEP-funded ASPIIRE and ILIAD Linking Partnership Projects at The Council for Exceptional Children. Every attempt has been made to faithfully reproduce the original content.

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IDEA'97

REGULATIONS

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Topic Brief 13

IDEA-PART B FINAL REGULATIONS*

Provisions of Special Interest to Teachers

(March 1999)

Below is a description of changes that have been made to the IDEA Part B final regulations (including certain items that have been retained, modified, or added since publication of the NPRM) that may be of special interest to teachers**.

Individualized Education Programs

(IEPs -- §§300.340-300.350)

1. **Regular Education Teacher on IEP Team Is Required By IDEA '97.**
   The final Part B regulations incorporate the requirements of IDEA '97 regarding regular education teachers in the IEP process, (i.e.:

   A. the IEP team must include at least one regular education teacher of the child (if the child is, or may be, participating in the regular education environment)
   (see §300.344(a)(2)); and

   B. the teacher must, to the extent appropriate, participate in the development, review, and revision of the child's IEP, including assisting in the determination of appropriate positive behavioral interventions and strategies for the child, and of the supplementary aids and services, program modifications, and supports for school personnel that will be provided for the child consistent with the IEP content requirements in §300.347(a)(3).
   (See §300.346(e).)

2. **Extent To Which Reg. Ed. Teacher Must Be Physically Present At IEP Meeting.**
   While at least one regular education teacher of a child with a disability must be a member of the IEP team (if the child is, or may be, participating in the regular education environment), the LEA need not require the teacher to -- (1) participate in all decisions made as part of the meeting, or (2) be present at all meetings or throughout an entire meeting, as described below:

   A. THE TEACHER WOULD PARTICIPATE IN DISCUSSIONS ABOUT the child's involvement and progress in the general curriculum and participation in the regular education environment (as well as discussions about the supplementary aids and supports for teachers and other school staff that are necessary to ensure the child's progress in that environment).

   B. THE TEACHER NEED NOT PARTICIPATE IN DISCUSSIONS about certain other matters in the IEP meeting (e.g., the physical therapy needs of the child -- if the teacher is not responsible for implementing that portion of the child's IEP).

C. WHETHER THE TEACHER MUST BE PHYSICALLY PRESENT AT EACH MEETING, and the extent to which the teacher must participate in all phases of the IEP process are matters that must -- (1) be determined on a case-by-case basis by the public agency, the parents, and the other members of the IEP team, and (2) be based on a variety of factors. (See analysis of comments on §300.344(a)(2) in Attachment 1, and Q-24 of Appendix A.)

3. **Teachers And Other Staff Must Have Access To, And Be Informed About, The IEP.**
The final regulations provide that each regular and special education teacher and service provider responsible for implementing a child's IEP must -- (1) have access to the child's IEP; and (2) be informed of his or her specific responsibilities under the IEP, and of the specific accommodations, modifications, and supports that must be provided for the child in accordance with the IEP.

4. **Designating A Public Agency Representative On IEP Team.**
A new §300.344(d) has been added to permit a public agency to designate another public agency member of the IEP team to also serve as the agency representative, if the criteria in §300.344(a)(4) are satisfied.

5. **Giving Parents A Copy Of IEP.**
The final regulations provide that parents must be given a copy of the child's IEP without cost and without having to request it.
(See §300.345(f).)

6. **Considering Each Child's Performance on General Assessments.**
The final regulations clarify that, in developing each child's IEP, the IEP team (in addition to considering the strengths of the child and the results of evaluations) also must consider "As appropriate, the results of the child's performance on any general State

or district-wide assessments."
(See §300.346(a)(1).)

7. **Consideration of Special Factors (Added Without Change From IDEA '97).**
   IDEA '97 required the IEP team to consider special factors related to each child. These statutory considerations, which were not changed in either the NPRM or the final regulations, include the following:

   A. BEHAVIOR THAT IMPEDES LEARNING. In the case of a child whose behavior impedes his or her behavior consider, if appropriate, strategies, including positive behavioral interventions, strategies, and supports to address that behavior.
   (See §300.346(a)(2)(i).)

   B. LIMITED ENGLISH PROFICIENCY. In the case of a child with limited English proficiency, consider the language needs of the child as they relate to the child's IEP.
   (See §300.346(a)(2)(ii).)

   C. BRAILLE NEEDS. In the case of a child who is blind or visually impaired, provide for instruction in braille ...unless the IEP team determines that it is not appropriate for the child.
   (See §300.346(a)(2)(iii).)

   D. COMMUNICATION NEEDS. "Consider the communication needs of the child, and in the case of a child who is deaf or hard of hearing, consider the child's language and communication needs..."
   (See §300.346(a)(2)(iv).)

   E. ASSISTIVE TECHNOLOGY. Consider whether the child requires assistive technology devices and services.
   (See §300.346(a)(2)(v).)

8. **IEP Accountability; Parent Right To Invoke Due Process.**
   The final regulations make clear that -- (1) each public agency, in addition to providing services, must make a good faith effort to assist the child to achieve the goals and objectives or benchmarks listed in the IEP; and (2) "Nothing in this section limits a parent's

> right to ask for revisions of the child's IEP or to invoke due process procedures if the parent feels that efforts required in paragraph (a) of this section are not being made."
> (See §300.350.)

Discipline Procedures

Introduction.
Prior to enactment of the IDEA Amendments of 1997, the statute only specifically addressed the issue of discipline in a provision that allowed school personnel to remove a child to an interim alternative educational placement for up to 45 days if the child brought a gun to school or to a school function. The 1997 Amendments incorporated prior court decisions and Department policy that had held that:

1. schools could remove a child for up to 10 school days at a time for any violation of school rules as long as there was not a pattern of removals;
2. a child with a disability could not be long-term suspended or expelled from school for behavior that was a manifestation of his or her disability; and
3. services must continue for children with disabilities who are suspended or expelled from school.

In addition, the 1997 Amendments:

1. expanded the authority of school personnel regarding the removal of a child who brings a gun to school, to also apply to all dangerous weapons and to the knowing possession of illegal drugs or the sale or solicitation of the sale of controlled substances; and
2. added a new ability of schools to request a hearing officer to remove a child for up to 45 days if keeping the child in his or her current placement is substantially likely to result in injury to the child or to others. The Amendments also added new provisions that require schools to assess a child's troubling behavior and develop positive behavioral interventions to address that behavior, and that describe how to determine whether the behavior was a manifestation of the child's disability.

The final regulations incorporate the statutory provisions described above, and provide additional specificity on a number of key issues:

Removals of Up to 10 School Days at a Time

- The regulations clarify that school personnel may remove a child with a disability for up to 10 school days, and for additional removals of up to 10 school days for separate acts of misconduct, as long as the removals do not constitute a pattern.

Providing Services During Periods of Disciplinary Removal

- Schools do not need to provide services during the first 10 school days in a school year that a child is removed.
- During any subsequent removal that is for 10 school days or less, schools provide services to the extent determined necessary to enable the child to appropriately progress in the general curriculum and appropriately advance toward achieving the goals of his or her IEP. In cases involving removals for 10 school days or less, school personnel, in consultation with the child's special education teacher, make the service determination.
- During any long-term removal for behavior that is not a manifestation of a child's disability, schools provide services to the extent determined necessary to enable the child to appropriately progress in the general curriculum and appropriately advance toward achieving the goals of his or her IEP. In cases involving removals for behavior that is not a manifestation of the child's disability, the child's IEP team makes the service determination.

Conducting Behavioral Assessments and Developing Behavioral Interventions

- Meetings of a child's IEP team to develop a behavioral assessment plan, or (if the child has one) to review the child's behavioral intervention plan, are only required when the child has first been removed from his or her current placement for more than 10 school days in a school year, and when commencing a removal that constitutes a change in placement.
- If other subsequent removals occur, the IEP team

members review the child's behavioral intervention plan and its implementation to determine if modifications are necessary, and only meet if one or more team members believe that modifications are necessary.

Change of Placement; Manifestation Determinations

- The regulations provide that a change of placement occurs if a child is removed for more than 10 consecutive school days or is subjected to a series of removals that constitute a pattern because they cumulate to more than 10 school days in a school year, and because of factors such as the length of each removal, the total amount of time the child is removed, and the proximity of the removals to one another.
- Manifestation determinations are only required if a school is implementing a removal that constitutes a change of placement.

Free Appropriate Public Education (FAPE) and Eligibility

1. **Comprehensive Evaluation**.
   The evaluation procedures in §300.532 have been amended to provide that each child's evaluation must be sufficiently comprehensive to identify all of the child's special education and related services needs, including any needs the child has that are commonly linked to a disability other than the disability in which the child has been classified.
   (See §300.532(h).)

2. **Ineligibility -- Lack of Instruction or Limited English Proficiency**.
   The final regulations clarify that a child may not be determined eligible under IDEA-Part B if "(1) The determinant factor for that eligibility determination is -- (i) Lack of instruction in reading or math; or (ii) limited English proficiency; and (2) the child does not otherwise meet the eligibility criteria under §300.7 (a)."

3. **Services Based on Identified Need**.
   The FAPE requirements in §300.300 have been amended to make clear that services provided to an eligible child must -- (A) address all of the child's special education and related services needs, and (B)

be based on the identified needs of the child, and not the child's disability category.
(See §300.300(a)(3).)

4. **Use of Assistive Technology in a Child's home if Needed for FAPE.**
   On a case-by-case basis, the use of school-purchased assistive technology devices in a child's home or in other settings is required if the child's IEP team determines that the child needs access to those devices in order to receive FAPE.
   (See §300.308.)

5. **Extended School Year (ESY) Services.**
   Section §300.309 (ESY services) has been amended to clarify that a public agency may not limit ESY services to particular categories of disability, or unilaterally limit the type, amount, or duration of those services.
   (See §300.309(a)(3).)

6. **Graduation Policy Retained; Prior Notice and Evaluation Addressed.**
   The final regulations retain the policy position that a student's right to FAPE is terminated upon graduation with a regular high school diploma, but is not terminated by any other kind of graduation certificate or diploma. The regulations also specify that --

   - WRITTEN PRIOR NOTICE IS REQUIRED in accordance with §300.503, because graduation from high school with a regular diploma constitutes a change in placement (see §300.122(a)(3)). School districts will be expected to provide the notice "a reasonable time" before proposing to graduate a student, in order to ensure that there is sufficient time for the parents and student to plan for, or challenge, the pending graduation.

     (See Analysis of Comments related to §300.122.)

   - EVALUATION IS NOT REQUIRED BEFORE GRADUATION (i.e., the provision requiring that a student be evaluated before determining that he or

she is no longer eligible under Part B does not apply if the termination of eligibility is due to graduation with a regular diploma or aging-out under state law).
(See §300.534(c).)

Children Experiencing Developmental Delays (§300.313).

- **Provisions Related to "Developmental Delay."**
  A new §300.313 has been added to -- (1) specify the conditions that states and LEAs must follow in using the term; and (2) clarify that a state or LEA that elects to use "developmental delay" also may use one or more of the disability categories for any child who has been determined (through the IDEA evaluation procedures) to have a disability and need special education. Thus, if a child has an identified disability (e.g., deafness), it would be appropriate to use the term with that child even if the state or LEA is using "developmental delay" for other children aged 3 through 9. The regulations also make clear that a state may adopt a common definition of "developmental delay" under Parts B and C of the Act.

Definitions

1. **Adding "ADD/ADHD" to "Child with a Disability."**
   "Attention deficit disorder" and "attention deficit hyperactivity disorder" have been added as conditions that could render a child eligible under the "other health impairment" category.
   (See §300.7(c)(9).)

2. **"Travel Training."**
   "Travel training" has been added to the definition of "special education," and defined to mean: "Providing instruction, as appropriate, to children with significant cognitive disabilities and any other children who require this instruction, to enable them to (i) develop an awareness of the environment in which they live; and (ii) learn the skills necessary to move effectively and safely from place to place within that environment (e.g., in school, in the home, at work, and in the community)."
   (See §300.26(b)(4).)

General Changes

1. **All notes in the NPRM have been removed** from the final regulations, and have been disposed of, as follows: The substance of the notes has been (1) added to the text of the regulations if it was considered to be a requirement; (2) added to Appendix A (formerly appendix C) if it was directly relevant to the Notice of Interpretation on IEPs; or (3) incorporated into the discussion of applicable comments in the Analysis of Comments and Changes. All other notes have been deleted.
   (See Attachment 3, described below, regarding the disposition of each note in the NPRM.)

2. **Two "Appendices"** have been included in the final regulations: Appendix A--Notice of Interpretation on IEPs; and Appendix B--Index to IDEA-Part B regulations.

3. **Three "Attachments"** have been added, as follows: Attachment 1-- Analysis of Comments and Changes; Attachment 2 -- Final Regulatory Flexibility Analysis; and Attachment 3 -- Table showing "Disposition of NPRM Notes in Final Regulations..."

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* On October 22, 1997, a Notice of Proposed Rulemaking (NPRM) was published in the ***Federal Register*** to amend the regulations under Part B of the Individuals with Disabilities Education Act (IDEA). The purposes of the NPRM were to implement changes made by the IDEA Amendments of 1997, and make other changes that facilitate the implementation of Part B. The changes made since the NPRM are based mainly on public comments received.

** The description of changes made to specific sections of the regulations since the NPRM does not include all changes made to those sections, nor does it include all changes in which teachers may have an interest. (For a more complete description, see "Major Changes..." in the preamble to the final regulations.)

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UPDATED 9/12/2001 by gkp

OSEP Office of Special Education Programs

IDEA'97 Provisions of Special Interest to Parents -- Topic Brief

March 1999

Below is a description of selected provisions in the final IDEA-Part B regulations (including certain items that have been retained, modified, or added since publication of the NPRM) that may be of special interest to parents**:

General Changes

1. **All notes in the NPRM have been removed** from the final regulations, and have been addressed, as follows: The substance of the notes has been (1) added to the text of the regulations if it was considered to be a requirement; (2) added to Appendix A (formerly Appendix C) if it was directly relevant to the Notice of Interpretation on IEPs; or (3) incorporated into the discussion of applicable comments in the Analysis of Comments and Changes. All other notes have been deleted.
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Definitions

1. **Adding "ADD/ADHD" to "Child with a Disability."**
   "Attention deficit disorder" and "attention deficit hyperactivity disorder" have been added as conditions that could render a child eligible under the "other health impairment" category.
   (See §300.7(c)(9).)
2. **"Parent Counseling and Training."**
   The statement, "helping parents to acquire the necessary skills that will allow them to support the implementation of their child's IEP or IFSP" has been added to the definition of "parent counseling and training."
   (See §300.24(b)(7).)
3. **"Travel Training."**
   "Travel training" has been added to the definition of "special education,"

and defined to mean: "Providing instruction, as appropriate, to children with significant cognitive disabilities and any other children who require this instruction, to enable them to (i) develop an awareness of the environment in which they live; and (ii) learn the skills necessary to move effectively and safely from place to place within that environment (e.g., in school, in the home, at work, and in the community)."
(See §300.26(b)(4).)

Free Appropriate Public Education (FAPE)

1. **Comprehensive Evaluation.**
   The evaluation procedures in §300.532 have been amended to provide that each child's evaluation must be sufficiently comprehensive to identify all of the child's special education and related services needs, including any needs the child has that are commonly linked to a disability other than the disability in which the child has been classified.
   (See §300.532(h).)
2. **Ineligibility -- Lack of Instruction or Limited English Proficiency.**
   The final regulations clarify that a child may not be determined eligible under IDEA-Part B if -- "(1) The determinant factor for that eligibility determination is-- (i) Lack of instruction in reading or math; or (ii) limited English proficiency; and (2) the child does not otherwise meet the eligibility criteria under §300.7(a)."
   (See §300.534(b).)
3. **Services Based on Identified Need.**
   The FAPE requirements in §300.300 have been amended to make clear that services provided to an eligible child must -- (A) address all of the child's special education and related services needs, and (B) be based on the identified needs of the child, and not the child's disability category.
   (See §300.300(a)(3).)
4. **Use of Assistive Technology in a Child's Home If Needed for FAPE.**
   On a case-by-case basis, the use of school-purchased assistive technology devices in a child's home or in other settings is required if the child's IEP team determines that the child needs access to those devices in order to receive FAPE.
   (See §300.308).
5. **Extended School Year (ESY) Services.**
   Section §300.309 (ESY services) has been amended to clarify that a public agency may not limit ESY services to particular categories of disability, or unilaterally limit the type, amount, or duration of those services.
   (See §300.309(a)(3).)
6. **Graduation policy retained; prior notice and evaluation addressed.**
   The final regulations retain the policy position that a student's right to FAPE is terminated upon graduation with a regular high school diploma, but is not terminated by any other kind of graduation certificate or diploma. The regulations also specify that --

- WRITTEN PRIOR NOTICE IS REQUIRED in accordance with §300.503, because graduation from high school with a regular diploma constitutes a change in placement (see §300.122(a)(3)). School districts will be expected to provide the notice "a reasonable time" before proposing to graduate a student, in order to ensure that there is sufficient time for the parents and student to plan for, or challenge, the pending graduation. (See Analysis of comments related to §300.122.)

- EVALUATION IS NOT REQUIRED BEFORE GRADUATION (i.e., the provision requiring that a student be evaluated before determining that he or she is no longer eligible under Part B does not apply if the termination of eligibility is due to graduation with a regular diploma or aging-out under state law).
  (See §300.534(c).)

Children with Disabilities in Public Charter Schools

- **Children and Parents Retain All Rights.**
  A new §300.312 has been added, which makes it clear that children with disabilities in public charter schools and their parents retain all rights under this part, and that compliance with Part B is required regardless of whether a public charter school receives Part B funds.

Children Experiencing Developmental Delays (§300.313).

- **Provisions Related to "Developmental Delay."**
  A new §300.313 has been added to -- (1) specify the conditions that states and LEAs must follow in using the term; and (2) clarify that a state or LEA that elects to use "developmental delay" also may use one or more of the disability categories for any child who has been determined (through the IDEA evaluation procedures) to have a disability and need special education. Thus, if a child has an identified disability (e.g., deafness), it would be appropriate to use the term with that child even if the state or LEA is using "developmental delay" for other children aged 3 through 9. The regulations also make clear that a state may adopt a common definition of "developmental delay" under Parts B and C of the Act.

Individualized Education Programs (IEPs--§300.340-300.350).

1. **Involving all Teachers And Service Providers Who Implement a Child's IEP.**
   To enhance implementation of each child's IEP, the final regulations provide that public agencies must ensure that -- (1) the IEP is accessible to each of the child's teachers and services providers; and (2) each teacher and provider responsible for implementing the IEP is informed of his or her responsibilities and of the specific accommodations, modifications and supports that must be provided for the child in accordance with the IEP.
   (See §300.142(b).)
2. **Regular Education Teachers as IEP Team Members.**

   The final regulations include the statutory requirements of IDEA '97 regarding regular education teachers on the IEP team (i.e., (A) the team must include at least one teacher, if the child is or may be participating in

the regular education environment (see 300.344(a)(2)), and (B) the teacher must, to the extent appropriate, participate in the IEP process, including assisting in the determination of positive behavioral interventions, and of supplementary aids, program modifications, and supports for school personnel that will be provided for the child.
(See §300.346(e).)

3. **Inviting "Other Individuals" to be on IEP Team.**
   To ensure that parents may invite any individual "with knowledge or special expertise" to be on the IEP team, the final regulations provide that the determination of the individual's knowledge or expertise is made by the party who invited the individual (i.e., the parents or the public agency).
   (See §300.344(c).)
4. **Informing Parents About "Other Individuals" on IEP Team.**
   The final regulations provide that public agencies must inform parents relating to the participation of other individuals on the IEP team who have knowledge or special expertise about the child (i.e., the ability of either party -- the parents or public agency -- to invite individuals with knowledge or special expertise to be on the IEP team.
   (See §300.345(b).)
5. **Considering Each Child's Performance on General Assessments.**
   The final regulations clarify that, in developing each child's IEP, the IEP team (in addition to considering the strengths of the child and the results of evaluations) also must consider "As appropriate, the results of the child's performance on any general state or district-wide assessments." (See §300.346(a)(1).)
6. **Consideration of Special Factors (Added without change from IDEA '97).**
   IDEA '97 required the IEP team to consider special factors related to each child. These statutory considerations, which were not changed in either the NPRM or the final regulations, include the following:

   A. BEHAVIOR THAT IMPEDES LEARNING.
      In the case of a child whose behavior impedes his or her behavior consider, if appropriate, strategies, including positive behavioral interventions, strategies, and supports to address that behavior.
      (See §300.346(a)(2)(i).)
   B. LIMITED ENGLISH PROFICIENCY.
      In the case of a child with limited English proficiency, consider the language needs of the child as they relate to the child's IEP.
      (See §300.346(a)(2)(ii).)
   C. BRAILLE NEEDS.
      In the case of a child who is blind or visually impaired, provide for instruction in braille ...unless the IEP team determines that it is not appropriate for the child.
      (See §300.346(a)(2)(iii).)
   D. COMMUNICATION NEEDS.
      "Consider the communication needs of the child, and in the

case of a child who is deaf or hard of hearing, consider the child's language and communication needs..."
(See §300.346(a)(2)(iv).)

E. ASSISTIVE TECHNOLOGY.
Consider whether the child requires assistive technology devices and services.
(See §300.346(a)(2)(v).)

7. **Parents to Receive Copy of IEP.**
The final regulations provide that parents must be given a copy of their child's IEP(s), without cost and without having to request it.
(See §300.345(f).)
8. **IEP Accountability; Parent Right to Invoke Due Process.**
The final regulations make clear that (A) each public agency, in addition to providing services, must make a good faith effort to assist the child to achieve the goals and objectives or benchmarks listed in the IEP; and (B) "Nothing in this section limits a parent's right to ask for revisions of the child's IEP or to invoke due process procedures if the parent feels that the efforts required in paragraph (a) of this section are not being made."
(See §300.350.)

Procedural Safeguards

1. **Independent educational evaluation (IEE).**
If a parent requests an IEE, a public agency may ask why the parent objects to the public evaluation, but may not require the explanation; and "the public agency may not unreasonably delay either providing the [IEE] at public expense or initiating a due process hearing to defend the public evaluation."
(See §300.502.)
2. **Parental consent.**
The final regulations on parental consent (1) replace "consent" with "informed parent consent;" (2) add "reevaluation" to the list of actions requiring consent; and (3) add that "A public agency may not use a parent's refusal to consent to one service or activity...to deny the parent or child any other service, benefit, or activity of the public agency, except as provided by this part." (See '300.505.) The regulations also provide that "With regard to services required to provide FAPE to an eligible child under this part, a public agency may access a parent's private insurance proceeds only if the parent provides informed consent consistent with §300.500(b)(1) [definition of "consent"]."
(See §300.152(f).)
3. **Mediation.**
The final regulations provide that if a mediator is not selected on a random (e.g., a rotation) basis from the state's list, both parties are involved in selecting the mediator and agree with the selection of the individual who will mediate.
(See §300.506(b)(2)(ii).)
4. **Change of Placement Based on Hearing Officer Decision.**
The final regulations provide that if a state hearing or review officer's decision agrees with the parent's position that a change in the child's

placement is appropriate, the decision must be implemented at that point, even if the public agency appeals that decision. This provision, which is consistent with most of the court decisions that have addressed this question, ensures that children will not remain in inappropriate placements for prolonged periods of time while a public agency appeals a decision in the parent's favor.
(See §300.514(c).)

Evaluation-Eligibility; Least Restrictive Environment (LRE).

1. **Procedures for Determining Eligibility--Obtaining Parent Input.**
   "Parent input" has been added to the variety of sources from which the public agency will draw in interpreting evaluation data for the purpose of determining a child's eligibility under this part.
   (See §300.535(a)(1).)
2. **LRE--Placements.**
   A new §300.552(e) has been added that prohibits the removal of a child with a disability from an age-appropriate regular classroom solely because of needed modifications in the general curriculum.

State Complaint Procedures

1. **Remedies for Denial of Appropriate Services.**
   The final regulations provide that if an SEA, in resolving a complaint, finds a failure to provide appropriate services to a child with a disability, the SEA must address: "(1) How to remediate the denial of those services, including, as appropriate, the awarding of monetary reimbursement or corrective action, which could include compensatory services or other corrective action appropriate to the needs of the child..."
   (See §300.660(b).)
2. **Complaints vs due process hearings.**
   A new §300.661(c) has been added to clarify that - (A) if an issue in a complaint is the subject of a due process hearing, that issue (but not any issue outside of the hearing) would be set aside until the conclusion of the hearing; (B) the decision on an issue in a due process hearing is binding; and (C) a public agency's failure to implement a due process decision would have to be resolved by the SEA.

Discipline Procedures

Introduction.
Prior to enactment of the IDEA Amendments of 1997, the statute only specifically addressed the issue of discipline in a provision that allowed school personnel to remove a child to an interim alternative educational placement for up to 45 days if the child brought a gun to school or to a school function. The 1997 Amendments incorporated prior court decisions and Department policy that had held that -- (1) schools could remove a child for up to 10 school days at a time for any violation of school rules as long as there was not a pattern of removals; (2) a child with a disability could not be long-term suspended or expelled from school for behavior that was a manifestation of his or her

disability; and (3) services must continue for children with disabilities who are suspended or expelled from school.

In addition, the 1997 Amendments (1) expanded the authority of school personnel regarding the removal of a child who brings a gun to school, to also apply to all dangerous weapons and to the knowing possession of illegal drugs or the sale or solicitation of the sale of controlled substances; and (2) added a new ability of schools to request a hearing officer to remove a child for up to 45 days if keeping the child in his or her current placement is substantially likely to result in injury to the child or to others. The Amendments also added new provisions that require schools to assess a child's troubling behavior and develop positive behavioral interventions to address that behavior, and that describe how to determine whether the behavior was a manifestation of the child's disability.

The final regulations incorporate the statutory provisions described above, and provide additional specificity on a number of key issues:

Removals of Up to Ten School Days at a Time.

- The regulations clarify that school personnel may remove a child with a disability for up to 10 school days, and for additional removals of up to 10 school days for separate acts of misconduct, as long as the removals do not constitute a pattern.

Providing Services During Periods of Disciplinary Removal.

- Schools do not need to provide services during the first 10 school days in a school year that a child is removed.

- During any subsequent removal that is for 10 school days or less, schools provide services to the extent determined necessary to enable the child to appropriately progress in the general curriculum and appropriately advance toward achieving the goals of his or her IEP. In cases involving removals for 10 school days or less, school personnel, in consultation with the child's special education teacher, make the service determination.

- During any long-term removal for behavior that is not a manifestation of a child's disability, schools provide services to the extent determined necessary to enable the child to appropriately progress in the general curriculum and appropriately advance toward achieving the goals of his or her IEP. In cases involving removals for behavior that is not a manifestation of the child's disability, the child's IEP team makes the service determination.

Conducting Behavioral Assessments and Developing Behavioral Interventions.

- Meetings of a child's IEP team to develop a behavioral assessment plan, or (if the child has one) to review the child's behavioral intervention plan, are only required when the child has first been removed from his or her current placement for more than 10 school days in a school year, and when commencing a removal that constitutes a change in placement.

- If other subsequent removals occur, the IEP team members review the child's behavioral intervention plan and its implementation to determine if modifications are necessary, and only meet if one or more team members believe that modifications are necessary.

Change of Placement; Manifestation Determinations.

- The regulations provide that a change of placement occurs if a child is removed for more than 10 consecutive school days or is subjected to a series of removals that constitute a pattern because they cumulate to more than 10 school days in a school year, and because of factors such as the length of each removal, the total amount of time the child is removed, and the proximity of the removals to one another.
- Manifestation determinations are only required if a school is implementing a removal that constitutes a change of placement.

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[*] On October 22, 1997, a Notice of Proposed Rulemaking (NPRM) was published in the ***Federal Register*** to amend the regulations under Part B of the Individuals with Disabilities Education Act (IDEA). The purposes of the NPRM were to implement changes made by the IDEA Amendments of 1997, and make other changes that facilitate the implementation of Part B. The changes made since the NPRM are based mainly on public comments received.

[**] The description of changes made to specific sections of the regulations since the NPRM does not include all changes made to those sections, nor does it include all changes in which parents may have an interest. (See "Major Changes..." in the preamble to the final regulations for a more complete description.)

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IDEAs that Work

IDEA '97
FINAL REGULATIONS

MAJOR ISSUES

The final regulations accompanying the Individuals with Disabilities Education Act (IDEA) amendments of 1997 appear in the March 12th *Federal Register*. Here are some of the major issues addressed in this package of regulations:

1. IEPS & GENERAL CURRICULUM:

Prior to 1997, the law did not specifically address general curriculum involvement of disabled students. The 1997 Amendments shifted the focus of the IDEA to one of improving teaching and learning, with a specific focus on the Individualized Education Program (IEP) as the primary tool for enhancing the child's involvement and progress in the general curriculum.

The final regulations reflect the new statutory language which requires that the Individualized Education Program for each child with a disability include:

- A statement of the child's present levels of educational performance including how the child's disability affects the child's involvement and progress in the general curriculum;
- A statement of measurable annual goals related to meeting the child's needs that result from the child's disability to enable the child to be involved in and progress in the general curriculum;
- A statement of the special education and related services and supplementary aids and services; and
- A statement of the program modifications or supports for school personnel that will be provided for the child to advance appropriately toward attaining the annual goals, be involved and progress in the general curriculum, and participate in extra curricular and other nonacademic activities and to be educated and participate with other children with disabilities and nondisabled children.

2. GENERAL STATE AND DISTRICT-WIDE ASSESSMENTS

The 1997 amendments specifically require that, as a condition of State eligibility for funding under Part B of IDEA, children with disabilities are included in general State and district-wide assessment programs. The amendments also address timelines and reporting requirements.

The final regulations essentially incorporate these statutory provisions on general State and district-wide assessments verbatim. These provisions require that States and LEAs must:

- Provide for the participation of children with disabilities in general State and district-wide assessments with appropriate accommodations and modifications in administration, if necessary;
- Provide for the conduct of alternate assessments not later than July 1, 2000 for children who cannot participate in the general assessment programs; and
- Make available, and report, to the public on the assessment results of disabled children, with the same frequency and in the same detail as reported on the assessment results of non disabled children.

3. REGULAR EDUCATION TEACHER INVOLVEMENT

Prior to 1997, the law did not include a regular education teacher as a required member of the Individualized Education Program team. Under the 1997 IDEA amendments, the IEP team for each child with a disability now must include at least one of the child's regular education teachers, if the child is, or may be, participating in the regular education environment. The new law also indicates that the regular education teacher, to the extent appropriate, participates in the development, review and revision of the IEP of the child.

The final regulations package clarifies that:

- If a child has more than one regular education teacher, the LEA may designate which teacher (or teachers) will be on the IEP team;
- Depending upon the child's needs and the purpose of the specific IEP team meeting, the regular education teacher need not be required to participate in all decisions made as part of the meeting or to be present throughout the entire meeting or attend every meeting;
- The extent to which it would be appropriate for the regular education teacher member of the IEP Team to participate in IEP meetings must be decided on a case-by-case basis, and,
- Each of the child's teachers, including the regular education teacher(s) and provider(s) must be informed of his or her responsibilities related to implementing the child's IEP and the specific accommodations, modifications, and supports that must be provided for the child.

4. GRADUATION WITH A REGULAR DIPLOMA

Neither the old or revised IDEA speaks directly to the issue of students with disabilities graduating with a regular high school diploma. However, the 1997 amendments placed greater emphasis on involvement of disabled students in the general curriculum and in State and district-wide assessment programs.

The final regulations incorporate the Department's long-standing policy position clarifying that:

- Graduation from high school with a regular diploma is considered a change in placement requiring written prior notice;
- A student's right to FAPE is terminated upon graduation with a regular high school diploma (The statutory requirement for reevaluation before a change in a student's eligibility does not apply.); and,
- A student's right to FAPE is not terminated by any other kind of graduation certificate or diploma.

5. DISCIPLINE

Prior to 1997, the statute only specifically addressed the issue of discipline in a provision that allowed personnel to remove a child to an interim alternative educational placement for up to 45 days if the child brought a gun to school or to a school function. The IDEA '97 incorporated prior court decisions and Department policy that allows schools to remove a child for up to ten school days at a time for any violation of school rules as long as there is not a pattern, and children with disabilities can not be long-term suspended or expelled from school for behavior that is a manifestation of his or her disability and services must continue for children with disabilities who are suspended or expelled from school. The IDEA '97 also expanded the authority of school personnel to remove to an interim alternative educational placement for up to 45 days to apply to all dangerous weapons and to knowing possession of illegal drugs and sale or solicitation of the sale of controlled substances and added a new ability of schools to request a hearing officer to remove a child for up to 45 days if keeping the child in his or her current placement is substantially likely to result in injury to the child or others. The amendments added provisions requiring schools to assess children's troubling behavior and develop positive behavioral interventions to address that behavior, and defining how to determine whether behavior is a manifestation of a child's disability.

The final regulations incorporate these statutory provisions and provide additional specificity on a number of key issues:

- **Services During Periods of Disciplinary Removal:** Schools do not need to provide services during the first ten school days in a school year that a child is removed.
- During any subsequent removal that is for less than ten school days, schools provide services to the extent determined necessary to enable the child to appropriately progress in the general curriculum and appropriately advance toward achieving the goals of his or her IEP. In cases involving removals for ten school days or less, school personnel, in consultation with the child's special education teacher, make the service determination.
- During any long-term removal for behavior that is not a manifestation of disability, schools provide services to the extent determined necessary to enable the child to appropriately progress in the general curriculum and appropriately advance toward achieving the goals of his or her IEP. In cases involving removals for behavior that is not a manifestation of the child's disability, the child's IEP team makes the service determination.

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- **Conducting Behavioral Assessments & Developing Behavioral Interventions:** Meetings of the IEP team to develop behavioral assessment plans or if the child has one, review the behavioral intervention plan, are only required when the child has first been removed from his or her current placement for more than ten school days in a school year and when commencing a removal that constitutes a change in placement. If other subsequent removals occur, the IEP team members review the child's behavioral intervention plan and its implementation to determine if modifications are necessary, and only meet if one or more team members believe that modifications are necessary.

- **Manifestation Determinations:** Manifestation determinations are only required if a school is implementing a removal that constitutes a change of placement.

- **Change of Placement:** The final regulations clarify that a change of placement occurs if a child is removed for more than ten consecutive school days or is subjected to a series of removals that constitute a pattern because they cumulate to more than ten school days in a school year, and because of factors such as the length of each removal, the total amount of time the child is removed, and the proximity of the removals to one another.

- **Removals of Up to Ten School Days at a Time:** The final regulations clarify that school personnel may remove a child with a disability for up to ten school days and for additional removals of up to ten school days for separate acts of misconduct as long as the removals do not constitute a pattern.

6. ATTENTION DEFICIT DISORDER & ATTENTION DEFICIT HYPERACTIVITY DISORDER

Neither the old nor revised IDEA included Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder as a separate disability category.

Relying on the Department's long-standing policy, the final regulations clarify that:

- ADD and ADHD have been listed as conditions that could render a child eligible under the "other health impaired"(OHI) category of Part B of IDEA; and,

- The term "limited strength, vitality, or alertness" in the definition of "OHI", when applied to children with ADD and ADHD, includes a child's heightened alertness to environmental stimuli that results in limited alertness with respect to the educational environment.

7. DEVELOPMENTAL DELAY

Prior to the 1997 IDEA amendments, States could define and require Local Education Agencies to use the developmental delay category for children ages 3 through 5. The 1997 IDEA amendments allowed States to define developmental delay for children ages 3 through 9 and authorized LEAs to choose to use the category and, if they do, they are required to use the State's definition.

The final regulations clarify that:

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- A State that adopts the term developmental delay determines whether it applies to children ages 3 through 9, or to a subset of that age range (e.g., ages 3 through 5);

- If an LEA uses the term developmental delay, the LEA must conform to both the State's definition of that term and to the age range that has been adopted by the State;

- If the State does not adopt the term developmental delay, an LEA may not independently use that term as a basis for establishing a child's eligibility under Part B of IDEA; and,

- Any State or LEA that elects to use the term developmental delay for children aged 3 through 9 may also use one or more of the disability categories for any child within that age range if it is determined, through the evaluation under Part B of IDEA, that the child has an impairment under Part B of IDEA, and because of that impairment needs special education and related services.

8. DEFINITION OF DAY & SCHOOL DAY

Prior to 1997, the law included only the term "day" that was interpreted by the Department to mean "calendar day." Now, law uses the terms "day," "business day," and "school day."

The final regulations clarify that:

- Day means calendar day, unless otherwise indicated as business day or school day;

- Business day means Monday through Friday, except for Federal and State holidays, unless holidays are specifically included in the designation of business day;

- School day means any day (including a partial day) that children are in attendance at school for instructional purposes; and,

- The term "school day" has the same meaning for all children with and without disabilities.

9. CHARTER SCHOOLS

The IDEA Amendments of 1997 contain two specific provisions on public charter schools, including requiring that: (1) in situations in which charter schools are public schools of the LEA, the LEA must serve children with disabilities in those schools in the same manner that it serves children with disabilities in its other schools, and provide Part B funds to those schools in the same manner as it provides Part B funds to its other schools; and (2) An SEA may not require a charter school that is an LEA to jointly establish its eligibility with another LEA unless it is explicitly permitted to do so under the State's charter school statute.

The final regulations clarify that:

- Part B final regulations apply to all public agencies, including public charter schools that are not included as LEAs or education service agencies (ESAs), and are not a school of an LEA or ESA;

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- The term LEA includes public charter schools that are established as an LEA under State law;
- The term "public agency" includes among the list of examples of a public agency, public charter schools that are not otherwise included as LEAs or ESAs and are not a school of an LEA or ESA;
- Children with disabilities who attend public charter schools and their parents retain all rights under Part B of IDEA; and,
- Compliance with Part B of IDEA is required regardless of whether a public charter school receives Part B funds.

10. PARENTALLY-PLACED CHILDREN WITH DISABILITIES IN PRIVATE SCHOOLS

Prior to 1997, the law did not extensively address the education of children with disabilities placed in private schools by their parents. These children were served based on the limnrolled by their parents in private schools.

For further information about the IDEA '97 statute and implementing regulations, contact the Department of Education at

202-205-5465 or 202-205-5507

or visit the Department's website at:

http:/www.ed.gov/offices/OSERS/IDEA

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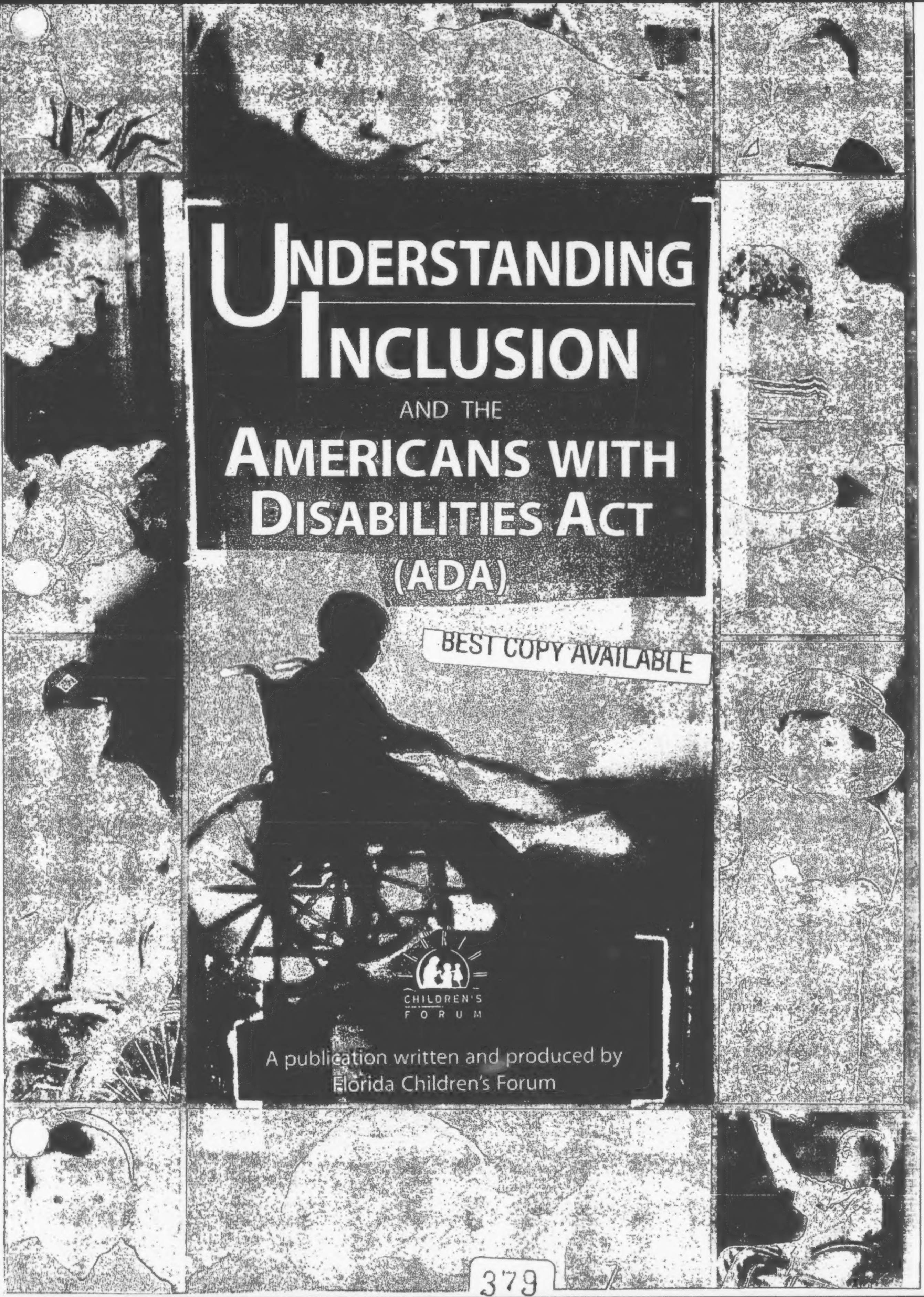

UNDERSTANDING INCLUSION

AND THE

AMERICANS WITH DISABILITIES ACT (ADA)

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CHILDREN'S FORUM

A publication written and produced by
Florida Children's Forum

UNDERSTANDING INCLUSION

AND THE

AMERICANS WITH DISABILITIES ACT

(ADA)

A resource to assist families, child care providers and advocates in planning and delivering child care for children with special needs

This booklet was made possible through the generous contributions of the

Florida Children's Forum
Florida Developmental Disabilities Council
The Florida Department of Health
The Florida Department of Children and Families

CHILDREN'S
FORUM

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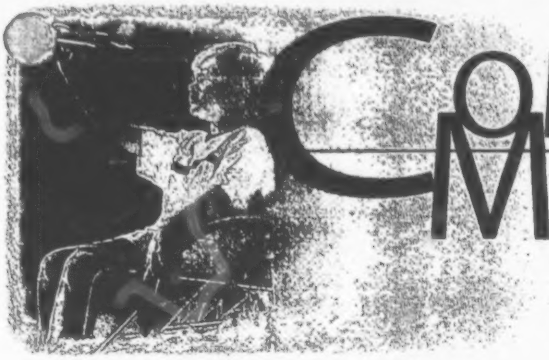
INTRODUCTION

What is Inclusion?

The Division of Early Childhood of the Council for Exceptional Children defines inclusion as:

"A value that supports the right of all children, regardless of their diverse abilities, to participate actively in natural settings within their communities.

A natural setting is one in which the child would spend time had he or she not had a disability. Such settings include but are not limited to home and family, play groups, child care, pre-schools, Head Start programs, kindergartens, and neighborhood school classrooms."



COMMON MISCONCEPTIONS

MISCONCEPTION:

All children with special needs require extra time and complicated care.

FACT:

No two children are alike; regardless of whether or not they have disabilities. Some children who have disabilities will need special care. Others will need little or no additional care. Like all children, children with special needs have unique personalities, strengths, interests and abilities. They are as diverse as any other group of children.

MISCONCEPTION:

All disabilities are visible.

FACT:

There are many types of disabilities; some are easily recognized, such as physical impairments or cerebral palsy. Other disabilities may not be apparent. These include visual impairments, hearing impairments, emotional or behavioral disorders, and learning disabilities.

Whether a disability is apparent or not, children must not be judged by a diagnosis. **It is important that caregivers take the time to get to know each child as an individual.**

MISCONCEPTION:

All children with mental disabilities have challenging behaviors.

FACT:

Just because a person has a mental disability, it does not mean that he or she has behavior problems. As with any group of children, those with special needs may have challenging or aggressive behaviors. Often this behavior is due to a child's frustration due to an inability to effectively communicate her/his needs. A patient, understanding caregiver can help by learning the child's signals, routines, likes and dislikes.

MISCONCEPTION:

Children with special needs should associate only with other children with special needs.

FACT:

All children benefit from associating with a wide range of individuals. All children, including children with special needs, gain valuable learning experiences by being together.

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BENEFITS OF INCLUSIVE CHILDCARE

Inclusive services help to ensure that children with and without disabilities experience the benefits of living and growing together.

Inclusive practices help create an atmosphere in which children are better able to accept and understand differences among themselves. Children begin to realize and accept that some people need to use wheelchairs, some people need to use hearing aids, and some use their arms and legs in different ways.

Children, families, child care providers, and the community all benefit by supporting inclusion.

Benefits for Children:

- Children develop friendships and learn how to play and interact with one another
- Children develop a more positive image of themselves and a healthy attitude about the uniqueness of others.
- Children are provided with models of people who achieve, despite challenges
- Children with special needs have opportunities to learn new skills by observing and imitating other children
- Children are encouraged to be resourceful, creative and cooperative

Benefits for Families:

- All families are supported to learn more about child development
- All families have the joy of watching their children make friends with a diverse group of children
- All families have an opportunity to teach their children about individual differences and diversity
- All families have an opportunity to talk with other parents and realize they share many of the same frustrations, concerns, needs, hopes, and desires for their children
- All families have access to child care

Benefits for Child Care Professionals

- Caregivers grow professionally by developing new skills and broadening their perspectives on child development
- Caregivers have an opportunity to learn about and develop partnerships with other community resources and agencies
- Caregivers learn to communicate more effectively and work as a team
- Caregivers build strong relationships with parents
- Caregivers enhance their credibility as quality, inclusive child care providers

Benefits for the Community:

- A community becomes more accepting and supportive of all people.
- A more diverse community leads to more creativity, possibilities and opportunities.
- Inclusion helps adults with disabilities to be better prepared for the responsibilities and privileges of community life.

QUESTIONS FREQUENTLY ASKED BY PROVIDERS OF CARE FOR CHILDREN WITH SPECIAL NEEDS

WILL ADMITTING CHILDREN WITH DISABILITIES DISRUPT MY DAY-TO-DAY FUNCTIONING?

No. You will still be able to use developmentally appropriate practices that emphasize individual growth patterns, strengths, interests, and experiences of young children. It will be relatively easy to integrate children with disabilities into a developmentally appropriate setting. Most changes are quite simple. For example, tactile materials can be used to meet the needs of a child with a visual impairment. Loving, caring, time, ingenuity, and good planning are among the ingredients needed to care for a child with disabilities.

WILL I NEED SPECIAL TRAINING TO CARE FOR A CHILD WITH DISABILITIES?

It depends on the child. Good basic child care skills and knowledge of child development are the foundation for quality care for all children. If caring for a child with disabilities does require additional skills, parents can often give you the training and information you need. Professional specialists who work with the child can also share tips, advice and strategies. Research indicates that specialized instruction is an important component of quality inclusive care. Support and technical assistance from parents and specialists may help to address a child's individual needs.

HOW DO I ANSWER QUESTIONS FROM OTHER CHILDREN ABOUT A CHILD'S DISABILITY?

Children are curious by nature. They ask questions about differences in people. When children ask questions, give them honest and straightforward answers. Always use the child's name in your answer. For example, "Chris gets food from that tube, just like you use a spoon." Parents of children with special needs often become experts in dealing with questions from children and adults. Ask them for tips in answering any questions you are not sure about.

WHAT IF OTHER CHILDREN'S PARENTS ARE CONCERNED THAT A CHILD WITH SPECIAL NEEDS WILL TAKE TIME AWAY FROM THEIR CHILD?

It is not unusual for parents to fear that a child with special needs will take time and attention away from their child. Talk openly with parents about their concerns. Encourage them to share any concerns that they have now or later. When you are doing these things, remember to respect the privacy of all families in your program. Do not share any personal information without first getting permission from the child's parents.

TIP: Share the "Benefits" Section of this guide with parents. Point out the benefits of inclusion to ALL children. Invite parents to be involved in your program and to participate in inclusive activities.

I HAVE A SMALL BUSINESS. HOW CAN I POSSIBLY MAKE ALL OF THE NECESSARY CHANGES?

The law has been crafted so the needs of the small business person were considered. Changes must be reasonable and easily achievable. For example, in most cases it is relatively inexpensive to build a ramp, widen one exterior door, and equip a unisex bathroom (with appropriate signage, two grab-bars, elevated stool, open handled door handles, and a wider door). In addition, you might want to consider installing indoor-outdoor carpeting to help ensure the safety of children.

Costly structural changes are absolutely not required if affordable alternatives are available (e.g., providing pitchers and cups rather than raising or lowering water fountains or changing a hinge on a door to facilitate wheelchair clearance rather than knocking down a wall).

BEST COPY AVAILABLE

WHAT DOES THE AMERICANS WITH DISABILITIES ACT (ADA) REQUIRE OF CHILD CARE PROVIDERS?

1. Remove barriers or provide alternative services so that facilities, services, programs, transportation, and communication are available to all children. For example, using a car to transport physically impaired children, rather than an on-lift bus or using the Florida Relay System instead of purchasing a TDD for deaf or hearing-impaired children or their families may be reasonable alternatives.
2. Consider a child's disability as merely a characteristic of the child. Do not deny admission based upon the disability.
3. Realize that if you, as either a center or home care provider, are receiving a subsidy for some children and also have some children for whom parents are paying, you must comply with Title II (public services) and Title III (public accommodations). The latter title specifies child care.
4. Eliminate any program standard that may result in children being screened out of your program. For example, if feeding themselves was a requirement, then some children with muscle spasticity could never enroll.
5. Revise the current enrollment form that you use for all children so that it includes asking parents if there is anything your staff needs to know to better care for their child including, but not limited to: allergies, sleep habits, hearing aids, needing a pacifier, wearing glasses, seizure disorder, other disability issues and custody issues.
6. Permit children with disabilities to have access to facilities, programs, services, communication and transportation at your center or home facility. In addition, depending upon the size of the facility and sources of funding, you may be required to comply with the employment provisions of Title I. As of July 26, 1995, any center with 15 or more employees must comply with Title I. If in doubt, consult your attorney.

In short, child care providers in both centers and homes are required to make programs, services and facilities available to children with disabilities. However they are not be required to add programs or services that are not provided for all other children. For example, if children ages 3-5 need to be potty trained to be admitted then the same rule would apply to children with disabilities. The ADA provides for equality, NOT for additional rights.

In this case, by spending a little money on renovations, you may be able to obtain tax credits from the IRS. Consult your tax advisor!

ARE FAMILY CHILD CARE HOMES ALSO RESPONSIBLE FOR THE IMPLEMENTATION OF ADA?

In general, the same rules apply. Children with disabilities must be able to get to, get in and use the facility. Family child care providers should participate in workshops in their area to learn about ADA. Becoming familiar with the needs of those with disabilities is a responsibility of the provider. Only those portions of the family child care home used in caring for children with disabilities must be made accessible.

CAN I REFUSE TO ADMIT A CHILD WHO HAS A DISABILITY IF I HAVE A POLICY TO THAT EFFECT?

No! In the past, various child care facilities have excluded children based upon policies. These policies are no longer possible and will not excuse you from meeting the ADA requirements. As long as the child with disabilities can be integrated and his or her needs can be reasonably accommodated, providers, regardless of size, will be obligated under the ADA to admit the child.

MUST I PROVIDE SPECIAL TOYS OR EQUIPMENT FOR CHILDREN WITH DISABILITIES?

Only in instances where the inclusion of the child with a disability in activities, programs, or services is contingent on the availability of that service, equipment, or toy. For example, it may be necessary to secure an interpreter, or a closed caption decoder, depending on the age and needs of a child with a hearing impairment. However, in many instances you can acquire the device from associations at no cost.

WHAT ARE MY RESPONSIBILITIES FOR ADA AS A BUSINESS PERSON?

As a child care center or family child care provider, you must be concerned about how ADA affects not only children but also possible employees who happen to have a disability. This includes anyone

- having a mental or physical impairment that limits one or more life activities;
- having a record of impairment; or,
- having been regarded as possessing an impairment.

This law is unusual because it

- helps children with disabilities to be admitted to a regular child care or family child care facility. Disability alone cannot be a reason for denial.
- makes it necessary to give consideration to qualified individuals with disabilities when employment opportunities become available at the child care or family child care facilities.
- requires that places of commerce (private businesses such as child care centers or family child care homes) make their programs, services, facilities, communication, and transportation accessible to individuals with disabilities.

ADA is NOT an affirmative action law. The child care or family child care provider has every right to employ the most qualified applicant. However, well-written policies and job descriptions are essential. Assessment procedures must fairly measure the potential of each applicant. Employers must be trained to interpret the Act's provisions correctly when several applicants appear to be equally qualified. Finally, the provider must avoid making judgments based on disability rather than ability. For example, it is illegal to ask how a disabled applicant would manage a lift on a bus. You could ask them to demonstrate how they would accomplish the task. You would have to ask every applicant to demonstrate the same thing.

WHAT HAPPENS TO MY LIABILITY INSURANCE WHEN I ENROLL A CHILD OR PERSON WITH A DISABILITY?

ADA requires that ALL child care centers and family child care facilities serve children with disabilities. The ADA does not prohibit insurers from canceling or not renewing the policy based upon provision of programs or services to children with disabilities. However, there is little evidence that insurers raise rates for inclusive settings. Daily rates for ALL parents could be changed – spreading added costs among ALL families just as you would do with other expenses.

ARE THERE SPECIAL BOOKKEEPING NOTATIONS NECESSARY WHEN WE ENROLL A CHILD OR PERSON WITH A DISABILITY?

Not really. However, it is important to spell out the parent's payment responsibilities in the event of the child's absence, as should be done for all children. You should also keep accurate health and medical records on all the children enrolled in your program.

CAN I GET A TAX BREAK FOR MAKING SPECIAL ACCOMMODATIONS?

Most likely you will not have to make major changes or spend extra money to serve children with special needs. If you do, you may be eligible for federal tax breaks to small businesses that make special accommodations for persons with disabilities. IRS Publication No.907 provides information on these provisions. You can get the publication by calling the IRS at 1-800-829-3676.

IF I RENT SPACE FOR MY CHILD CARE FACILITY, WHO PAYS FOR CHANGES TO MEET ADA REQUIREMENTS?

The law is really unclear on this issue. ADA only suggests how to handle this obligation. The law says that both the landlord and the tenant are responsible. A general rule for implementation is:

- The landlord should be responsible for "readily achievable" barrier removal and assistive devices located in "common areas" within a multiple unit structure such as an apartment or commercial building.
- The tenant is responsible for making changes (that are readily achievable and with prior permission of the landlord) inside the rental unit used for child care.

As you renew your lease, you should clarify these obligations. Remember you must obtain the landlord's written permission prior to making any permanent modifications to the structure unless you have blanket permission to do otherwise.

USING THE TEAM APPROACH

Being on the Child's Team

Many children with special needs receive services from a team of people. The team begins with the family and may also include a speech therapist, physical therapist, support coordinator, occupational therapist, early intervention/early childhood special education specialist (for children birth to five), special education teacher (for children six to 21), nurse, or mental health therapist. As a child care provider you can be an important part of this team.

What can you offer to the team?

As a child care professional you spend many hours with a child. You can see the child interact with other children, see changes in his or her growth and development, and see signs of illness or distress.

This gives you important information to share with others who are working with the child. Your information will help team members know a child better and help them set appropriate goals for the child to work toward.

Specialists may ask for specific types of information, such as changes in a child's behaviors or times when the child's energy levels are very low. Writing down brief notes will help you remember and share this information. You can also help team members to remember the positives! Therapists must often focus on concerns, so you can play an important role by pointing out gains the child has made in your setting.

How can others on the child's team help you?

"Teaming" with parents and professionals can be an extra benefit of caring for a child with special needs. With the parent's permission, service providers can:

- Help you learn how to respond to certain behaviors.
- Help you know which things a child can or cannot do.
- Explain how to handle special health care needs.
- Let you know when you need to be especially careful with a child.
- Tell you about other helpful services and resources.

A specialist may even be able to provide services in your child care setting. For example, a therapist might come to help a child with physical therapy exercises (which gives you a chance to learn, too).

How do I become part of a child's team?

Ask parents about services their child is receiving. Be clear that you are only interested in the information they wish to share. Ask for permission to talk with service providers and determine if there are particular things that the parents want you to share with the providers.

Parents can tell you about the types of professionals that are working with their child and how to contact them. Encourage parents to give your phone number to service providers so they can call you with their questions. Be sure to have parental permission before you talk to a specialist. Agencies will usually require written permission prior to discussing a child with you.

Being Part of a Plan

Each child from birth to 36 months who is receiving Department of Health/Children's Medical Services/ Early Intervention has a Family Support Plan (FSP). A school age child (age 3 to 21) receiving special education service will have an Individualized Education Plan (IEP). The child's team (family and service providers) develops these plans. FSP's and IEP's include goals and resources to increase the child's ability to learn. With parental permission, you may ask for a copy of the FSP and IEP. Knowing what the plan says will help you assist a child in meeting his or her goals. Parts of the plans may even be implemented in your child care facility.

Parents may request that you be involved in developing a child's FSP or IEP. FSP and IEP meetings usually take place at least once during the year. If you are able to attend, take notes during the meeting so you can refer to them when needed. You can also bring your notes about things you have observed in your child care setting. This will help you share the child's accomplishments. Parents can request that meetings take place at times and locations that are accessible to you. Ask if this is a possibility for team meetings, at least on an occasional basis. If you cannot go to meetings ask what information you can send with parents or call in to other team members. Ask them to keep you updated, especially about any decisions made at the meeting that relate to your time with the child.

I.D.E.A.

Individuals with Disabilities Education Act

The Individuals with Disabilities Education Act (IDEA) requires states to provide a free appropriate public education to eligible children and youth with disabilities. The 1997 revisions to the Act strengthened early childhood services. There are three major provisions:

- Part C Infants and Toddlers Program
- Part B Education for Children with Disabilities Ages 3 through 21
- Section 619, the Preschool Grants Program

Part C

Included in this act is Part H/C (federal entitlement program); a statewide, community based, comprehensive, coordinated, family-focused, multidisciplinary, interagency program of early intervention services for infants and toddlers with established conditions or developmental delays and their families.

The Part H/C program serves infants and toddlers from **birth to 36 months** who have an established medical condition that places them at high risk for developmental disabilities or who have a developmental delay.

FAMILY SUPPORT PLAN (FSP)

Part H/C services include identification, evaluation, service coordination, and Family Support Plan (FSP) development, as well as early intervention services such as physical therapy, occupational therapy, special instruction and family support services. Services are based on the concerns and priorities of the child's parents and FSP team and the outcomes described in the plan. The program was implemented in Florida in September 1993 through the Department of Health, Children's Medical Services/Early Intervention Program.

This plan is developed by the family and early intervention team and explains what services a family will receive. Once needs are identified, the plan is used to ensure the services are provided.

The FSP should include:

1. How your baby is growing and learning
2. Your family's concerns, priorities and resources
3. Major things the family wants to happen to their child (outcomes)
4. Services a family may need to help their child grow and learn
5. Dates when the services will start
6. How often services will be given
7. Where services will be given
8. How long services will continue
9. Name of their primary service coordinator
10. Transition plans for the child as their needs change and as the goals for the child and family are achieved
11. Required signatures
12. Who will pay for the services

I.D.E.A.

Individuals with Disabilities Education Act – Part B

Part B applies to children with disabilities ages **three through twenty-one**, who have not graduated from high school. This part of the law entitles eligible children to receive special education and related services. A child is eligible when the requirements listed in the State Board of Education Rules for Exceptional Student Education have been met.

The special education program provides teaching, special materials, and other needed educational services. The program must be appropriate, free of charge and set up to meet the needs of the child as agreed upon by the parents and the school. Decisions about the child must be made after an individual evaluation. The program for the child must be described in writing in an Individual Education Plan (IEP). For students ages three through five years, a Family Support Plan (FSP) or an IEP may be written. Decisions about the child must be made with the parents. The program is administered through the Florida Department of Education. The local school board or district office can provide the name and phone number of the Administrator, Exceptional Student Education.

NOTE: It is ***optional*** for the local school boards to serve children ***birth to 36 months*** who meet the eligibility criteria for Part C.

INDIVIDUAL EDUCATION PLAN (IEP)

Every child who receives Exceptional Student Education (ESE) services has an IEP that describes the student's needs, educational goals and the types of educational and related services the child will receive at school. Some children with disabilities receive physical, speech and/or occupational therapy in the school setting. While children are receiving ESE services, they may not have a service coordinator or support coordinator through the school, someone such as a teacher or therapist will coordinate the child's educational program.

Section 619

The Preschool Grants program, authorizes grants to all states for services for children with disabilities ages three through five and for continuity of special education services for children moving out of Part C.

Section 504 of the Rehabilitation Act

Prohibits discrimination against children and adults on the basis of a disability by any program or activity receiving federal financial assistance. Section 504 applies to public or private preschools, child care centers, Head Start/Early Head Start, or family child care homes that receive federal funds either directly or through a grant, loan, or contract.

RESOURCES FOR CHILDREN WITH SPECIAL NEEDS AND THEIR FAMILIES

Head Start Services to Children with Disabilities

Since 1972, Head Start programs have reserved at least 10 percent of their enrollment for children with disabilities. The Head Start Performance Standards assert that all eligible children, including children with disabilities, are to receive Head Start services and be included in the full range of activities normally provided to all Head Start children. These programs must also make provisions to meet the special needs of children with disabilities as specified in each child's IEP or FSP. Head Start programs work closely with Local Education Agencies and other service providers to provide a continuum of services that consider the needs and strengths of each child.

Early Head Start services are available for children from birth to age three, and regular Head Start services are available for children from age three to mandatory school age. The emphasis on family focused services in Head Start ensures that the program addresses the resources, priorities and concerns of the family and supports the family in meeting the developmental needs of their child.

Developmental Services (DS)

Developmental Services for children age three through school age focus mainly on supports in the home and do not duplicate services provided through the school. Depending on the eligibility of the child, services may be funded through State General Revenue or through the Medicaid Home and Community Based Waiver for the Developmentally Disabled. Funding for these services is limited and might not be available in all areas of the state. No matter how a child receives services through the DS program, they will have a support coordinator to determine eligibility for the program and identify supports available to the child and family. Many adults with developmental disabilities also receive services and supports from the Developmental Services Program Office, Department of Children and Families. An array of services is available and can include supported employment or day training programs, homemaker respite services, transportation, behavioral training, therapy services, equipment and supplies.

Subsidized Child Care

Subsidized Child Care is a privatized system based on income eligibility and parental choice. The Department of Children and Families has historically contracted with 25 community-based Child Care Coordinating Agencies serving all 67 counties. The source of those dollars is federal, state, and local matching funds. The Florida Partnership for School Readiness assumed the lead agency role for the federal Child Care and Development Block Grant late in 2000. Subsidized Child Care dollars will be administered under the direction of local school readiness coalitions.

The local agencies make child care available through vouchers or subcontracts with private centers, family child care homes, faith-based providers, legally-exempt providers and relatives. Parents choose the child care provider that best meets their family's needs. Young children in the Subsidized Child Care Program currently represent more than 14% of the children birth to five enrolled in Florida, and are using 11,318 different providers. School-age children receiving subsidies represent more than 20% of those enrolled in licensed and exempt school age programs.

Child Care Resource and Referral Network

The Department of Children and Families has contracted with a private, nonprofit agency, the Florida Children's Forum, to manage Florida's Child Care Resource and Referral Network (CCR&R). The Child Care Resource and Referral (CCR&R) Network was established by statute (402.27.F.S.) in 1989 for two major purposes:

(1) to help parents find child care that best meets their children's needs, and

(2) to provide technical assistance in developing resources to address the availability and affordability of child care.

Along with Subsidized Child Care, the oversight of the Resource and Referral Network has been transferred to the Florida Partnership for School Readiness.

The network has expanded their services to include an Inclusion Coordinator at each child care coordinating agency to provide training and technical assistance to child care providers that serve children with special needs.

Florida Directory of Early Childhood Services Central Directory Network

Federal funds allocated through the Individuals with Disabilities Act (I.D.E.A.) and administered through Florida Department of Health, Children's Medical Services Infant and Toddler Early Intervention Program support the Florida Central Directory Network. The Department of Health has contracted with a private, non-profit agency; the Florida Children's Forum, to manage the Network.

The Florida Directory of Early Childhood Services (Central Directory) program provides information and referral on disabilities and special health care needs for families, service coordinators and other professionals that work with children with special needs.

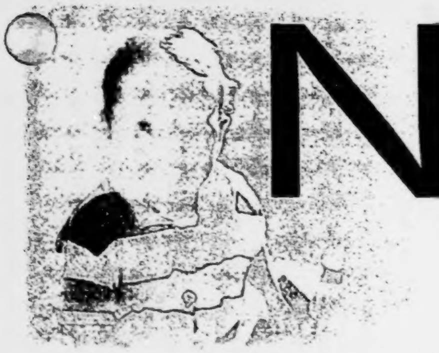
The network has the responsibility of promoting public awareness of and education about the Central Directory and in conjunction with local planning groups providing technical assistance to the Infant and Toddler Early Intervention Programs.

CHILDREN'S
FORUM

"Making Florida A Quality Child Caring State"

FCF is a statewide network of child care professionals, business and political leaders, government entities, families and individuals who share a common vision to make Florida a quality child caring state. As part of this mission, FCF conducts research, training, and advocacy on behalf of children, families, child care providers and employers. Today, after providing more than a decade of quality service in Florida, the FCF is a nationally recognized leader in the child care industry.

The Florida Children's Forum is a clearinghouse for current events, information, research, resources and policies pertaining to the child care industry and the children and families that are impacted by that industry. FCF is a national child care leader and advocates on a daily basis to improve the affordability, availability and quality of child care in Florida.



NATIONAL ORGANIZATIONS

ADA Information, National Office

The ***Department of Justice*** operates an ADA Information Line. Information Specialists are available to answer general and technical questions during business hours on the weekdays. The Information Line also provides 24-hour automated services for ordering ADA materials and an automated fax back system that delivers technical assistance materials to fax machines or modems.

Tel:	(800) 514-0301 (voice) (800) 514-0383 (TDD)
Fax:	Automated fax back only
Internet:	www.usdoj.gov/crt/ada/adahom1.htm

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Child Care Law Center

The Child Care Law Center is a national non-profit legal services organization founded in 1978. CCLC's primary objective is to use legal tools to foster the development of high quality, affordable child care for every child, every parent and every community.

Tel:	(415) 495-5498
Fax:	(415) 495-6734
Email:	strohl@childcarelaw.com
Internet:	www.childcarelaw.org

The Council for Exceptional Children (CEC), Division for Early Childhood (DEC)

CEC is a nonprofit organization advocating for individuals who work with or an behalf of children with special needs, birth through age eight, and their families. The Division is dedicated to promoting policies and practices that support families and enhance the optimal development of children.

Tel.:	(800) 232-7733 or (303) 620-4579
Email:	dec_execoff@ceo.cudenver.edu
Internet:	www.dec-sped.org/dec.html

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ERIC Clearinghouse on Elementary & Early Childhood Education (ERIC/EECE)

ERIC is one of 16 clearinghouses in the ERIC system, which is part of the National Library of Education, funded by the Office of Educational Research and Improvement (OERI), U.S. Department of Education. ERIC clearinghouses identify and select documents and journal articles, and then prepare entries describing the documents and articles to be incorporated in the ERIC database, the world's most frequently used collection of information on education. Clearinghouses also publish digests, monographs, and other publications; answer questions; disseminate information on the Internet; and represent ERIC at conferences and workshops.

Tel:	(800) 583-4135 (voice/TTY) or (217) 333-1386 (voice/TTY)
Fax:	(217) 333-3767
Email:	ericeece@uiuc.edu
Internet:	http://ericeece.org

Federal Resource Center for Special Education

The FRC is a five-year contract between the Academy for Educational Development, its partner, the National Association of State Directors of Special Education (NASDSE) and the U.S. Department of Education, Office of Special Education Programs. The FRC supports a nationwide technical assistance network to respond to the needs of children and youth with disabilities, especially students from under-represented populations.

Tel: (202) 884-8215
Fax: (202) 884-8200
Email: FRC@AED.org
Internet: www.dssc.org/FRC/index.htm

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The National Association for the Education of Young Children (NAEYC)

NAEYC is the nation's largest organization of early childhood professionals and others dedicated to improving the quality of early childhood education and programs for children. It offers many services, including publications.

Tel: (800) 424-2460 or (202) 232-8777
Fax: (202) 328-1846
Email: naeyc@naeyc.org
Internet: www.naeyc.org

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National Child Care Information Center (NCCIC)

Provider information on child care.

Tel: (800) 616-2242
Fax: (609) 758-4660
Email: bscott@nccic.org
Internet: www.nccic.org

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National Early Childhood Technical Assistance System

This is a consortium working to support states, jurisdictions, and others to improve services and results for young children with disabilities and their families.

Tel: (919) 962-2001 voice
or (877) 574-3194 TDD
Fax: (919) 966-7463
Email: nectas@unc.edu
Internet: www.nectas.unc.edu

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The National Information Center for Children and Youth with Disabilities (NICHCY)

"Topical sheets" on specific disabilities are available to the general public.

Tel: (800) 695-0285
or (202) 884-8200 (voice/TTY)
Fax: (202) 884-8441
Email: nichcy@aed.org
Internet: http://www.nichcy.org

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National Institute on Disability & Rehabilitation Research

Ten ADA regional technical assistance centers.

Tel: (800) 949-4232
Fax: (703) 525-3585
Internet: www.ed.gov/offices/OSERS/NIDRR

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Zero to Three/National Center for Infants, Toddlers and Families

This is the nation's leading resource on the first three years of life. It is a national non-profit charitable organization whose aim is to strengthen and support families, practitioners and communities to promote the healthy development of babies and toddlers.

Tel: (202) 638-1144
Fax: (202) 638-0851
Email: 0to3@zerotothree.org
Internet: http://www.zerotothree.org

ACRONYMS & ABBREVIATIONS

Disabilities, Health Conditions and Related Services

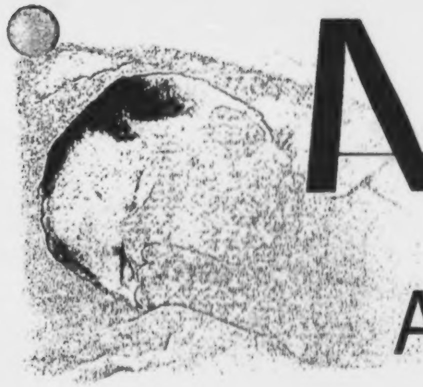
Professionals frequently use abbreviations to form acronyms to describe terms. The disability field is no exception. These are some of the more commonly used acronyms and the term each describes. These terms cover the areas of disabilities and health conditions, and services and related medical terms. This information is designed especially for parents of infants with disabilities and professionals serving those families.

Disabilities, Health Conditions and Related Services on Both National and State Levels

ADA	Americans with Disabilities Act
ADC	Adult Disabled Children; Aid to Dependent Children (more commonly called AFDC)
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
ADL	Activities of Daily Living
AFDC	Aid to Families with Dependent Children
AHCA	Agency for Health Care Administration
ARC	Association for Retarded Citizens
ASD	Autism Spectrum Disorders
ASHA	American Speech/Language Hearing Association
AT	Assistive Technology
BD	Behavior Disorder
BISCS	Bureau of Instructional Support and Community Services
BPD	Bronchopulmonary Dysplasia
CA	Chronological Age
CAN	Child Abuse and Neglect
C.A.R.D.	Center for Autism and Related Disabilities
CAT Scan	Computerized Axial Tomography (sometimes referred to as CT Scan)
CBC	Complete Blood Count
CCR&R	Child Care Resource & Referral
CD	Central Directory, Florida Directory of Early Childhood Services
CDB	Childhood Disability Benefit
CDH	Congenital Diaphragmatic Hernia
CEC	Council for Exceptional Children
CF	Cystic Fibrosis
CHD	Congenital Heart Disease
CHRIS	Children's Registry & Information System
CHS	Children's Home Society
CMS	Children's Medical Services
CMV	Cytomegalovirus
CNS	Central Nervous System
CP	Cerebral Palsy
CPAP	Continuous Positive Airway Pressure
CPHU	County Public Health Unit
CS	Cesarean Section
CSF	Cerebrospinal Fluid
DAC	Disabled Adult Child
DBS	Division of Blind Services
DCF	Department of Children and Families
DD	Developmental Disabilities
DDC	Developmental Disabilities Council
DEI	Developmental Evaluation and Intervention
D&E	Diagnosis and Evaluation
DOE	Department of Education
DOH	Department of Health
DS	Developmental Services
Dx	Diagnosis
ECG	Electrocardiogram
ECMO	Extracorporeal Membrane Oxygenation
ED/EH	Emotional Disorder/Emotionally Handicapped
EEG	Electroencephalogram
EI	Early Intervention
EIP	Early Intervention Program
EMR/EMH	Educable Mentally Retarded/ Handicapped
ENT	Ear, Nose and Throat
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
ESE	Exceptional Student Education
FAPE	Free Appropriate Public Education
FAS	Fetal Alcohol Syndrome
FDLRS	Florida Diagnostic & Learning Resources System
FEFP	Florida Education Funding Program
FHR	Fetal Heart Rate
FICCIT	Florida Interagency Coordinating Council for Infants and Toddlers
FL ARF	Florida Association for Rehabilitation Facilities
FND	Family Network on Disabilities
FRS	Family Resource Specialist
FSDB	Florida School for the Deaf and Blind

FSP	Family Support Plan
FTE	Full Time Equivalency
FTT	Failure to Thrive
GI	Gastrointestinal
HHSB	Health and Human Services Board
HI/HH	Hearing Impaired/Handicaps
HMO	Health Maintenance Organization
HRAC	Human Rights Advocacy Committee
Hx	History
IBC	Infant Bioethics Committee
ICC	Interagency Coordinating Council
ICF	Intermediate Care Facility
ICRC	Infant Care Review Committee
ID	Immune Deficiency
IDEA	Individuals with Disabilities Education Act
IDT	Interdisciplinary Team
IEP	Individualized Education Plan
IFSP	Individualized Family Service Plan (Florida's Family Support Plan)
IH	Infantile Hydrocephalus
IHP	Individualized Habilitation Plan
I&O	Intake and Output
IQ	Intelligence Quotient
I&R	Information & Referral
IS	Infant Stimulation
ISP	Individual Service Plan
ITP	Individualized Transition Plan
IUGR	ntrauterine Growth Retardation
IVH	Intraventricular Hemorrhage
IV	Intravenous
LBR	Legislative Budget Request
LBW	Low Birth Weight
LD	Learning Disability
LEA	Local Education Agency
LICC	Local Interagency Community Collaboration
LRE	Least Restrictive Environment
LT	Language Therapy
MA	Mental Age
MBD	Minimal Brain Dysfunction
MCH	Maternal and Child Health
MD	Muscular Dystrophy
MDT	Multidisciplinary Team
MR	Mental Retardation
MRI	Magnetic Resonance Imaging
MS	Multiple Sclerosis
NAEYC	National Association for the Education of Young Children
NEC	Necrotizing Enterocolitis
NEC*TAS	National Early Childhood*Technical Assistance System
NICHCY	National Information Center for Children and Youth with Disabilities
NICU	Neonatal Intensive Care Unit
NORD	National Organization for Rare Disorders
NPND	National Parent Network on Disabilities
NPO	Nothing by mouth
NSVD	Normal Spontaneous Vaginal Delivery
NTD	Neural Tube Defect
OH	Orthopedically Handicapped
OI	Osteogenesis Imperfecta
OM	Otitis Media
OSEP	Office of Special Education Programs
OT	Occupational Therapy/Therapist
PASS	Plan for Achieving Self-Support
PCA	Personal Care Attendant
PDD	Pervasive Developmental Disorder
PH	Physically Handicapped
PI	Physically Impaired
PICU	Pediatric Intensive Care Unit
PKU	Phenylketonuria
PMR/PMH	Profoundly Mentally Retarded/ Handicapped
PPEC	Prescribed Pediatric Extended Care
PRN	Whenever Necessary
PRO	Parent Resource Organization
PSC	Primary Service Coordinator
PT	Physical Therapy/Therapist
RDS	Respiratory Distress Syndrome
REFER	Software the Central Directory Network is using
RPC	Regional Policy Council
RPICC	Regional Perinatal intensive Care Center
R&R	Resource and Referral
RT	Recreational Therapy
Rx	Prescription
SCAN	Suspected Child Abuse and Neglect
SEA	State Education Agency
SED	Severely Emotionally Disturbed
SEDNET	Severely Emotionally Disturbed Network
S/LI	Speech/Language Impaired
S/LT	Speech/Language Therapy
SGA	Small for Gestational Age
SIDS	Sudden Infant Death Syndrome
SLD	Specific Learning Disabilities
SSDI	Social Security Disability Income
SSI	Supplementary Security Income
ST	Speech Therapy
TA	Technical Assistance
TDD	Telecommunications Device for the Deaf
TMR/TMH	Trainable Mentally Retarded/ Handicapped
TPN	Total Parental Nutrition
Tx	Treatment
UCP	United Cerebral Palsy
URI	Upper Respiratory Infection
UTI	Urinary Tract Infection
VE	Varying Exceptionalities
VI/VH	Visually Impaired/Handicapped
VLBW	Very Low Birth Weight
VR	Vocational Rehabilitation
VS	Vital Signs
WIC	Women, Infants and Children Program

TBC



MEDICAL CONDITIONS AND DISORDERS

PHYSICAL DISABILITY, IMPAIRMENT OR DELAY

Any of a variety of conditions that may be due to muscular, skeletal or neuro-muscular disorders, paralysis or loss of one or more limbs which impose physical limitations of the individual including an impaired ability to walk, stand or use one's hands.

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- **Articulation Disorders** – same as above.
- **Echolalia**- An automatic repetition of sounds, words and phrases, including responding to questions by repeating the ending of the question rather than processing and answering it.
- **Cleft lip/cleft palate** – A congenital fissure in the upper lip and/or the roof of the mouth which forms a communicating passageway between the mouth and nasal cavities. This condition may lead to articulation and voice problems.

SEIZURE DISORDERS

Seizures are characterized by uncontrolled movements of the muscles of the body or change in alertness or behavior. They are caused by certain abnormalities in the brain. In the normal brain, there is organized electrical activity which is always present. A seizure happens when bursts of unorganized electrical impulses interfere with the normal brain electrical activity. A burst is the sudden appearance of electrical impulses. The different types of seizures are caused by different kinds of electrical bursts or by electrical bursts in different parts of the brain.

- **Tonic-clonic (also known as Grand mal)** seizures are the most common type of seizure. First the child goes through the tonic phase with loss of consciousness, stiffening of the body, drooling, heavy breathing, and at times loss of bladder and bowel control. This followed by the clonic phase during which the muscles change from rigid to relaxed. The seizure is often followed by a post-ictal state which is a period of sleepiness or confusion.

- **Absence (Petit mal)** – These seizures often involve very brief periods of staring as if the child is daydreaming. Often the child will have no change in muscle tone. For example, if standing the child does not fall. There will be a momentary loss of consciousness and the child will not know what happened during the brief time of the seizure.

- **Infantile (Infantile myoclonic)** – Occur during the first two years of life and usually before one year of age. During infantile seizures, children may demonstrate different signs of seizure activity, such as brief nodding of the head or flexing the head and arms many times during the day.

- **Partial – simple (focal)** – seizure may involve any part of the body. The term simple means that generally there is no loss of consciousness.

- **Complex (psychomotor)** – seizures are similar to the simple partial seizures in that only a part of the body is involved. The term complex means that there is the additional component of mental confusion, behavioral symptoms and loss of consciousness. These seizures are often followed by a period of confusion.

ADHD/ADD

(Attention deficit disorder with hyperactivity)/ (attention deficit disorder without hyperactivity)

A disorder in which developmentally inappropriate inattention and impassivity are exhibited. There are two subtypes: Attention deficit disorder with hyperactivity and attention deficit disorder without hyperactivity. Some characteristics are: not staying on task, difficulty organizing and completing work, inability to stay with activities for periods of time appropriate for child's age, failure to follow through on parental requests. Symptoms may vary with situation and time, i.e. home, school, groups, and one-on-one interactions.

AUTISM

A lifelong developmental disability which affects communication and behavior and which usually appears before age three. It is characterized by lack of meaningful speech or inappropriate speech; withdrawn, anti-social and/or affectionless behavior; a fascination with objects rather than with people; prolonged odd body movements; a hypersensitivity to stimuli; stereotypic and compulsive behavior; and a failure to initiate or relate to people.

CYSTIC FIBROSIS

An inherited disease that affects the pancreas, respiratory system and sweat glands, which usually begins in infancy and is characterized by chronic respiratory infection, pancreatic insufficiency and heat intolerance. Prognosis is not good as there is no cure, but antibiotics and new treatments have prolonged the life of many patients.

DIABETES

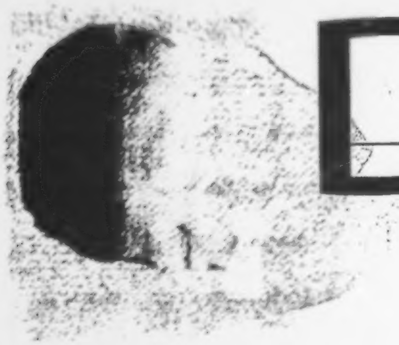
A disorder in which the pancreas produces too little insulin with the result that the body is unable to adequately metabolize sugar. Principal symptoms are elevated blood sugar, sugar in the urine, excessive urine production and increased food intake. Complications of diabetes if left untreated include low resistance to infections leading to a susceptibility to gangrene, cardiovascular and kidney disorders, disturbances in the electrolyte balance and eye disorders, some of which may lead to blindness.

SEVERE ALLERGIES

A condition in which the individual has an acquired hypersensitivity to substances that normally do not cause a reaction. Manifestations most commonly involve the respiratory tract or skin and include eczema, hives, nasal discharge and inflammation of the nasal mucous membrane.

SEVERE ASTHMA

A disorder of the bronchial system that is characterized by labored breathing accompanied by wheezing that is caused by a spasm of the bronchial tubes or by swelling of their mucous membrane. Recurrence and severity of attacks is influenced by secondary factors: mental or physical fatigue, exposure to fumes, endocrine changes at various periods in life and emotional situations.



DICTIONARY OF TERMS USED IN SPECIAL EDUCATION

Note: The following definitions have been compiled from a variety of sources. The content of this dictionary does not necessarily represent definitions endorsed by the U.S. Department of Education.

Adaptive development
Development of the child in comparison to other children the same age. This might include the child's ability to dress, eat without the assistance of others, toilet training, how he plays with other children, how he plays alone, understanding dangers in crossing the street, how he behaves if mother leaves the room, etc.

Advocate
Someone who takes action to help someone else (as in "Educational advocate"); also, to take action on someone's behalf

Amendment
Change, revision, or addition made to a law

Appeal
A written request for a change in a decision; also, to make such a request

Appropriate
Able to meet a need; suitable or fitting; in special education, it usually means the most normal situation possible

Assessment
A collecting and bringing together of information about a child's needs, which may include social, psychological, and educational evaluations used to determine services; a process using observation, testing, and test analysis to determine an individuals' strengths and weaknesses in order to plan his or her educational services

Assessment team
A team of people from different backgrounds who observe and test a child to determine his or her strengths and weaknesses

At risk
A term used with children who have, or could have, problems with their development that may affect later learning

Child Find
A service directed by each state's Department of Education or lead agency for identifying and diagnosing unserved children with disabilities; while Child Find looks for all unserved children, it makes a special effort to identify children from birth to six years old

Cognitive
A term that describes the process people use for remembering, reasoning, understanding, and using judgment; in special education terms, a cognitive disability refers to difficulty in learning

Comprehensive service system
Refers to a list of 14 areas each participating state is to provide under the Early Intervention Program for Infants and Toddlers (Part H). These 14 points range from definition of developmentally delayed, to guidelines for identification, assessment, and provision of early intervention services for the child and family

Counseling
Advice or help given by someone qualified to give such advice or help (often psychological counseling)

Developmental
Having to do with the steps or stages in growth and development before the age of 18 years

Developmental history
The developmental progress of a child (ages birth to 18 years) in such skills as sitting, walking, talking or learning

Developmental tests
Standardized tests that measure a child's development as it compares to the development of all other children at that age

Disability

The result of any physical or mental condition that affects or prevents one's ability to develop, achieve, and/or function in an educational setting at a normal rate

Due process (procedure)

Action that protects a person's rights in special education, this applies to action taken to protect the educational rights of students with disabilities

Early interventionist

Someone who specializes in early childhood development, usually having a Master's degree or Ph.D. in an area related to the development of infants, toddlers, and preschoolers

Early intervention policies

See policy/policies

Early intervention services or programs

Programs or services designed to identify and treat a developmental problem as early as possible; before age 2-3 (services for 3-5 year olds are referred to as preschool services)

Eligible

Able to qualify

Evaluation (as applied to children from birth through two years of age)

The procedures used to determine if a child is eligible for early intervention services; (as applied to preschool and school-aged children) the procedures used to determine whether a child has a disability and the nature and extent of the special education and related services the child needs

Free appropriate public education [often referred to as FAPE]

One of the key requirements of the IDEA, which requires that an education program be provided for all school-aged children (regardless of disability) without cost to families; the exact requirements of "appropriate" are not defined, but other references within the law imply the most "normal" setting available

Handicap

See disability

Identification

The process of locating and identifying children needing special services

Lead agency

The agency (office) within a state or territory in charge of overseeing and coordinating the service system for children ages birth through 2

Least Restrictive Environment (LRE)

An educational setting or program that provides a student with disabilities with the chance to work and learn to the best of his or her ability; it also provides the student as much contact as possible with children without disabilities, while meeting all of the child's learning needs and physical requirements

Multidisciplinary

A team approach involving specialists from more than one discipline, such as a team made up of a physical therapist, a speech and language pathologist, a child development specialist, an occupational therapist, or other specialists as needed

Occupational therapy

A therapy or treatment provided by an occupational therapist that helps individual developmental or physical skills that will aid in daily living; it focuses on sensory integration, on coordination of movement, and on fine motor and self-help skills, such as dressing, eating with a fork and spoon, etc,.

Parent training and information programs

Programs that provide information to parents of children with special needs about acquiring services, working with schools and educators to ensure the most effective educational placement for their child, understanding the methods of testing and evaluating a child with special needs, and making informed decisions about their child's special needs

Physical therapy

Treatment of (physical) disabilities given by a trained physical therapist (under doctor's orders) that includes the use of massage, exercise, etc, to help the person improve the use of bones, muscles, joints and nerves

Placement

The classroom, program, service, and/or therapy that is selected for a student with special needs

Policy/policies

Rules and regulations; as related to early intervention and special education programs, the rules that a state or local school system has for providing services for and educating its students with special needs

Private agency

A non-public agency which may be receiving public funds to provide services for some children

Private therapist

Any professional (therapist, tutor, psychologist, etc.) not connected with the public school system or with a public agency

Program(s)

In special education, a service, placement, and/or therapy designed to help a child with special needs

Psychologist

A specialist in the field of psychology, usually having a Master's degree or Ph.D. in psychology

Public agency

An agency, office or organization that us supported by public funds and serves the community at large

Public Law (P.L.) 94-142

A law passed in 1975 requiring that public schools provide a "free appropriate public education" to school-aged children ages 3-21 (exact ages depend on your state's mandate., regardless of disabling condition; also called the *Education For All Handicapped Children Act of 1975* or the *Education of the Handicapped Act (EHA)*, with recent amendments now called the *Individuals with Disabilities Education Act (IDEA)*

Public Law (P.L.) 102-119

Passed in 1991, this is an amendment to the Individuals with Disabilities Education Act (IDEA), which requires states and territories to provide a "free appropriate public education" to all children ages 3-5; and provides funds for states and territories to plan and implement a comprehensive service system for infants and toddlers (ages birth through 2 years) with disabilities

Related services

transportation and development, corrective, and other support services that a child with disabilities requires in order to benefit from education, examples of related services include speech/language pathology and audiology, psychological services, physical an occupational therapy, recreation, counseling services, interpreters for those with hearing impairments, medical services for diagnostic and evaluation purposes, and assistive technology devices and services

Service coordinator

Someone who acts as a coordinator of an infant's or toddler's services, working in partnership with the family and providers of special programs; service coordinators may be employed by the early intervention agency

Services/service delivery

The services (therapies, instruction, treatment) given to a child with special needs

Social or emotional (development)

The psychological development of a person in relation to his or her social environment

Special education

See special education programs and services

Special education coordinator

The person in charge of special education programs at the school. District. Or state level

Special education programs/services

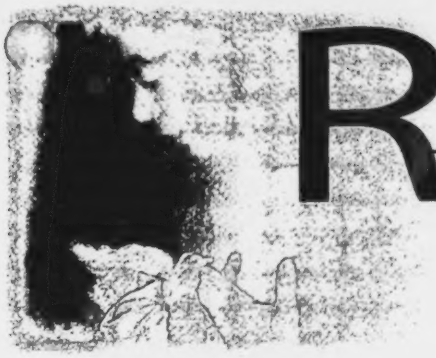
Programs, services, or specially designed instruction (offered at no cost to families) for children over 3 years old with special needs who are found eligible for such services; these include special learning methods or materials in the regular classroom and special classes and programs if the learning or physical problems indicate this type or program

Special needs – (as in "special needs" child)

A term to describe a child who has disabilities or who is at risk of developing disabilities and who, therefore, requires special services or treatment in order to progress

Speech/language pathology

A planned program to improve and/or correct communication problems



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Tallahassee, FL 32399-0700

Kim Latta
Florida Developmental Disabilities Council
124 Marriott Drive – Suite 203
Tallahassee, FL 32301

For additional information concerning children with disabilities and special health care needs or to request additional copies, please call:

The Florida Directory of Early Childhood Services (Central Directory Network)

1-800-654-4440

prepared by

The Florida Children's Forum
2807 Remington Green Circle
Tallahassee, FL 32308

Tel: (850) 487-6301
Fax: (850) 922-9156
Email: lalong@centraldirectory.org

www.centraldirectory.org

INCLUSIVE CHILD CARE

CHILDREN WITH DISABILITIES AND SPECIAL HEALTH CARE NEEDS

LIST OF TERMS BOOKLET

Making
Florida
a
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Updated 2000 Edition

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Any of a number of conditions that interfere with the individual's ability to produce audible utterances to such a degree that the resultant sounds do not serve satisfactorily as the basic tool for oral expression. Speech disabilities fall into several categories; articulation problems in which speech sounds are omitted, replaced by substitute sounds or distorted; voice problems in which pitch, loudness or quality of voice are affected; and stuttering.

- **Articulation Disorders** – same as above.
- **Echolalia-** An automatic repetition of sounds, words and phrases, including responding to questions by repeating the ending of the question rather than processing and answering it.
- **Cleft lip/cleft palate** – A congenital fissure in the upper lip and/or the roof of the mouth which forms a communicating passageway between the mouth and nasal cavities. This condition may lead to articulation and voice problems.

SEIZURE DISORDERS –

Seizures are characterized by uncontrolled movements of the muscles of the body or change in alertness or behavior. They are caused by certain abnormalities in the brain. In the normal brain, there is organized electrical activity which is always present. A seizure happens when bursts of unorganized electrical impulses interfere with the normal brain electrical activity. A burst is the sudden appearance of electrical impulses. The different types of seizures are caused by different kinds of electrical bursts or by electrical bursts in different parts of the brain.

- **Tonic-clonic** (also known as Grand mal) seizures are the most common type of seizure. First the child goes through the tonic phase with loss of consciousness, stiffening of the body, drooling, heavy breathing, and at times loss of bladder and bowel control. This is followed by the clonic phase during which the muscles change from rigid to relaxed. The seizure is often followed by a period of sleepiness or confusion.

- **Absence (Petit mal)** – These seizures often involve very brief periods of staring as if the child is daydreaming. Often the child will have no change in muscle tone. For example, if standing the child does not fall. There will be a momentary loss of consciousness and the child will not know what happened during the brief time of the seizure.

- **Infantile (Infantile myoclonic)** – These seizures occur during the first two years of life and usually before one year of age. During infantile seizures, children may demonstrate different signs of seizure activity, such as brief nodding of the head or flexing the head and arms many times during the day.

- **Partial – simple (focal)** seizures may involve any part of the body. The term simple means that generally there is no loss of consciousness.

- **Complex (psychomotor)** – seizures are similar to the simple partial seizures in that only a part of the body is involved. The term complex means that there is the additional component of mental confusion, behavioral symptoms and loss of consciousness. These seizures are often followed by a period of confusion.

ADHD/ADD
(Attention Deficit Disorder with Hyperactivity)/
(Attention Deficit Disorder without Hyperactivity)–
A disorder in which developmentally inappropriate inattention and impassivity are exhibited. There are two subtypes: Attention Deficit Disorder with Hyperactivity and Attention Deficit Disorder without Hyperactivity. Some characteristics are: not staying on task, difficulty organizing and completing work, inability to stay with activities for periods of time appropriate for child's age, failure to follow through on parental requests. Symptoms may vary with situation and time, i.e. home, school, groups, and one-on-one interactions.

AUTISM –
A lifelong developmental disability which affects communication and behavior and which usually appears before age three. It is characterized by lack of meaningful speech or inappropriate speech; withdrawn, anti-social and/or affectless behavior; a fascination with objects rather than with people; prolonged odd body movements; a hypersensitivity to stimuli; stereotypic and compulsive behavior; and a failure to initiate or relate to people.

CYSTIC FIBROSIS –
An inherited disease that affects the pancreas, respiratory system and sweat glands, which usually begins in infancy and is characterized by chronic respiratory infection, pancreatic insufficiency and heat intolerance. Prognosis is not good as there is no cure, but antibiotics and new treatments have prolonged the life of many patients.

DIABETES–

A disorder in which the pancreas produces too little insulin with the result that the body is unable to adequately metabolize sugar. Principal symptoms are elevated blood sugar, sugar in the urine, excessive urine production and increased food intake. Complications of diabetes if left untreated include low resistance to infections leading to a susceptibility to gangrene, cardiovascular and kidney disorders, disturbances in the electrolyte balance and eye disorders, some of which may lead to blindness.

SEVERE ALLERGIES –

A condition in which the individual has an acquired hypersensitivity to substances that normally do not cause a reaction. Manifestations most commonly involve the respiratory tract or skin and include eczema, hives, nasal discharge and inflammation of the nasal mucous membrane.

SEVERE ASTHMA --

A disorder of the bronchial system that is characterized by labored breathing accompanied by wheezing that is caused by a spasm of the bronchial tubes or by swelling of the mucous membrane. Recurrence and severity of attacks is influenced by secondary factors: mental or physical fatigue, exposure to fumes, endocrine changes at various periods in life and emotional situations.

(under Federal law)

Included in this act is **Part H/C** (federal entitlement program): a statewide, community-based, comprehensive, coordinated, family-focused, multidisciplinary, interagency program of early intervention services for infants and toddlers with established conditions or developmental delays and their families.

The Part H/C program serves infants and toddlers from ***birth until their third birthday*** who have an established medical condition that places them at high risk for developmental disabilities or who have a developmental delay.

Part H/C services include identification, evaluation, service coordination, and Family Support Plan (FSP) development, as well as early intervention services such as physical therapy, occupational therapy, special instruction and family support services. Services are based on the concerns and priorities of the child's parents and FSP team and the outcomes described in the plan. The program was implemented in Florida in September 1993 through the Department of Health, Children's Medical Services/Early Intervention Program.

Part B applies to children with disabilities ages ***three through twenty-one***, who have not graduated from high school. This part of the law entitles eligible children to receive special education and related services. A child is eligible when they meet the requirements listed in the State Board of Education Rules for Exceptional Student Education.

The special education program provides teaching, special materials, and other needed educational services. The program must be appropriate, free of charge and set up to meet the needs of the child as agreed upon by the parents and the school. Decisions about the child must be made after an individual evaluation. The program for the child must be described in writing in an Individual Education Plan (IEP). For students ages three through five years, a Family Support Plan (FSP) or an IEP may be written. Decisions about the child must be made with the parents. The program is administered through the Florida Department of Education. The local school board or district ofice can provide the name and phone number of the Administrator, Exceptional Student Education.

NOTE: It is ***optional*** for the local school boards to serve children ***birth until their third birthday*** who meet the eligibility criteria for Part C.

CHILDREN'S MEDICAL SERVICE (CMS) NETWORK – A special program for children who have chronic conditions or have special health care needs.

Ages – Birth through 18

Restrictions – A household of four making less than $2,742 per month (200% FPL) requires medical eligibility. For children with special health care needs such as Spina Bifida, Leukimia and Diabetes.

Cost – No more than $15 per household for a family making less than $2,742 per month (200% FPL).

MEDICAID EARLY INTERVENTION SERVICES -- Eleven services specifically designed for the purpose of identifying developmental delays in a Medicaid–eligible child at the earliest age as possible, and optimizing the child's functioning capacity. Must be:

- provided by a Medicaid-enrolled licensed healing arts professional or paraprofessional;
- medically necessary, as defined by Medicaid;
- designed to meet the developmental needs of the child who is developmentally delayed or has a condition that could result in a developmental delay; and,
- authorized in the Family Support Plan.

WITH DISABILITIES

Since 1972, Head Start programs have reserved at least 10 percent of their enrollment for children with disabilities. The Head Start Performance Standards assert that all eligible children, including children with disabilities, are to receive Head Start services and be included in the full range of activities normally provided to all Head Start children. These programs must also make provisions to meet the special needs of children with disabilities as specified in each child's IEP or FSP. Head Start programs work closely with Local Education Agencies and other service providers to provide a continuum of services that consider the needs and strengths of each child.

Early Head Start services are available for children from birth to age three, and regular Head Start services are available for children from age three to mandatory school age. The emphasis on family focused services in Head Start ensures that the program addresses the resources, priorities and concerns of the family and the supports and services a family needs for meeting the developmental needs of their child.

DEVELOPMENTAL SERVICES (DS) –

These services are for children age ***three through school age***,and focus mainly on supports in the home. They do not duplicate services provided through the school.

Depending on the eligibility of the child, services may be funded through state General Revenue or through the Medicaid Home and Community Based Waiver for the Developmentally Disabled. Funding is limited and may not be available in all areas of the state.

Regardless of the services received through the DS program, each child has a support coordinator that determines their eligibility and identifies supports available to them and their family.

Many adults with developmental disabilities also receive services and supports from the Developmental Services Program Office, Department of Children and Families. An array of services are available and can include: supported employment or day training programs, homemaker and respite services, transportation, behavioral training, therapy services and equipment and supplies.

FAMILY SUPPORT PLAN (FSP) –

This plan is developed by the family and early intervention team and explains what services a family will receive. Once needs are identified, the plan is used to ensure the services are provided. The FSP should include:

1. How your baby is growing and learning
2. Your family's concerns, priorities and resources
3. Major things the family wants to happen to their child (outcomes)
4. Services a family may need to help their child grow and learn
5. Dates when the services will start
6. How often services will be given
7. Where services will be given
8. How long services will continue
9. Name of their primary service coordinator
10. Transition plans for the child as their needs change and as the goals for the child and family are achieved
11. Required signatures
12. Who will pay for the services.

INDIVIDUAL EDUCATION PLAN (IEP) --

Every child who receives exceptional student education services (ESE) has an IEP that describes the student's needs, educational goals and the types of educational and related services the child will receive at school. Some children with disabilities receive physical, speech and occupational therapy in the school setting. While children receiving ESE services do not have a service coordinator or support coordinator through the school, someone such as a teacher or therapist will coordinate the child's educational program.

AHEAD (At HomE and At Daycare) -- Training for providers about resources for infants and toddlers and young children with special needs, their families and their child care providers. Topics include care in the developmental areas of communication, language, motor, play/social, and self-help skills.

MAINSTREAMING WORKS --
Training to encourage the inclusion of children with disabilities in child care by promoting positive attitudes creating developmentally appropriate environments and providing resources and information.

MITCH (Module of Interdisciplinary Training for Children with Handicaps) -- (*soon to be* **GROW TO FIVE**)
Training to assist local school districts in providing interdisciplinary training and resources to parents and early education and care providers who work with children ages 0-5; including children who are developing typically, children who may be at risk, and children with special needs.

NEW FRIENDS --
Training designed to address the need for structured activities to facilitate the integration of preschool children with disabilities into the regular classroom setting. Training focuses on the following attitudinal variables:

- The teacher's confidence in his/her ability to teach children with disabilities
- The teacher's belief that children with disabilities can become useful members of society
- The teacher's belief that children with disabilities should be educated with their non-disabled peers

SPECIAL CHILDREN, SPECIAL CARE --
Training to assist families and caregivers of children who are medically-complex and technology-dependent to live in the least restrictive environment possible and have access to intervention.

BEST COPY AVAILABLE

Questions concerning children with disabilities and special health care needs? Please call the Florida Directory of Early Childhood Services (Central Directory) 1-800-654-4440.

Florida Children's Forum
2807 Remington Green Circle
Tallahassee, FL 32308
(850) 921-5444
fax: (850) 681-9816

www.centraldirectory.org

FLORIDA DEPARTMENT OF
HEALTH

FLORIDA
DEVELOPMENTAL
DISABILITIES
COUNCIL, INC.

FLORIDA
CHILDREN'S
FORUM

FLORIDA DEPARTMENT OF
CHILDREN
& FAMILIES

Florida Department of
Education

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Forms

- **Classroom Observation Report**
- **Sample Pages from the Family Support Plan (Early Intervention Program)**
- **Individualized Education Plan (Mailman Center for Child Development)**
- **Internal Referral/Follow-up Form**
- **Observation of Pre-kindergarten Student Behavior** – English & Spanish
- **Child/Family Questionnaire**
- **Parent denial of consent**
- **Referral for assessment**
- **Special Instruction Consultant Service Plan**
- **Staff/Parent Consultation Form**
- **Teacher's list of children with possible special needs**

Classroom Observation Report

-Mailman Center for Child Development-

Fax (305) 243-3410

Child's Name: ____________________ **Date of Birth:** ____________

Center: __________________________ **Date of Observation:** _______

Teacher's Name: __________________

Purpose of Observation:

Observation:

Recommendations:

____

Signature of Observer

FLORIDA'S FAMILY SUPPORT PLAN

Form B
Page__of__

FSP Date:______________________

Name:______________________
ID. Number:______________________
DOB:______________________

Family Concerns and Priorities

As a participant you may provide as much or as little information for this page as you are comfortable providing. This information is voluntary and will not have any bearing on the determination to provide services.

Family's Areas of Concern: What concerns do you have about yourself or your child? (Possible areas: developmental issues, social/community supports, health, pregnancy, parent support, child care, education, budgeting, transportation, shelter/food, employment, legal assistance, counseling, etc.)

Priorities: What concerns are most important for yourself, your child, and/or your family?

Resources: What resources do you have that you could use to meet your or your child's needs? Who or what else would help? What strengths do you, your child, and/or your family have that will help reach the outcomes you want to achieve?

Date and Initial any changes or updates to this page

HRSF 96-102

FLORIDA'S FAMILY SUPPORT PLAN

Form D
Page __ of ___

FSP Date: ____________________

Name: ____________________
ID. Number: ____________________
DOB: ____________________

Outcome/Action to Take

Outcome:

What do you want for yourself, your child, and/or your family? (Use a separate page for each outcome) How and when will progress toward achieving this outcome be determined?

Action to Take: What Events or Activities Must Occur to Achieve this Outcome?

What, How, and Where will this happen? Who will provide this service?	When will this happen? (Include a beginning and ending date; and the recommended frequency and intensity.)	Who is responsible for follow-up on this service? Who is responsible for payment?

Outcome Update(s) or Change(s)

Describe the change(s) agreed upon or the updated information

I agree to the changes noted here: Family Signature: ____________________ Date: __________
Primary Service Coordinator Signature: ____________________ Date: __________
Other Signature/Title: ____________________ Date: __________

INDIVIDUAL EDUCATION PLAN:
INSTRUCTIONAL GOALS AND OBJECTIVES

Child's Name: ___________________________

Birth date: _____________________________

Center: ________________________________

36-42 MONTHS

Social-Emotional Development

- ❖ _____ Identifies self as girl or boy, and a member of a specific family and cultural group.
- ❖ _____ Shows pride in heritage and background.
- ❖ _____ Demonstrates increasing independence.
- ❖ _____ Demonstrates trust in adults.
- ❖ _____ Shows ability to separate from parents.
- ❖ _____ Sings simple songs, rhymes, and fingerplays.
- ❖ _____ Participates in routine activities.
- ❖ _____ Helps put things away with assistance.
- ❖ _____ Plays independently.
- ❖ _____ Plays simple group games.
- ❖ _____ Engages in imaginative play.
- ❖ _____ Completes a task.
- ❖ _____ Follows rules.
- ❖ _____ Begins to take turns and shares.
- ❖ _____ Expresses feelings.
- ❖ _____ Attends to short stories for 5 to 10 minutes.

Mailman Center for Child Development
(305) 243-6624

INDIVIDUAL EDUCATION PLAN:
INSTRUCTIONAL GOALS AND OBJECTIVES

Child's Name: ______________________________
Birth date: ________________________________
Center: ___________________________________

42-48 MONTHS

Social-Emotional Development

- ____ Plays interactive games- exhibits associative play.
- ____ Plays with peers with a minimal amount of conflict.
- ____ Asks permission to use items belonging to others.
- ____ Demonstrates trust in adults.
- ____ Helps others in need.
- ____ Works cooperatively with others on completing a task.
- ____ Uses compromise and discussion to resolve conflicts.
- ____ Demonstrates interest and participates in classroom activities.
- ____ Accepts responsibility for maintaining the classroom environment.
- ____ Shares and respects the right of others.
- ____ Follows rules.
- ____ Expresses feelings.

Mailman Center for Child Development
(305) 243-6624

INDIVIDUAL EDUCATION PLAN:
INSTRUCTIONAL GOALS AND OBJECTIVES

Child's Name: ____________________________
Birth date: ______________________________
Center: _________________________________

36-42 MONTHS

Fine Motor Development

- ____ Builds a nine-block tower.
- ____ Strings 1-inch beads.
- ____ Stirs liquid with a spoon.
- ____ Puts objects in a container.
- ____ Works with clay.
- ____ Completes simple inset puzzle.
- ____ Strokes with a paintbrush.
- ____ Scribbles.

INDIVIDUAL EDUCATION PLAN:
INSTRUCTIONAL GOALS AND OBJECTIVES

Child's Name: ____________________________

Birth date: ______________________________

Center: _________________________________

42-48 MONTHS

Fine Motor Development

- _____ Easily uses scissors to cut paper into two pieces.
- _____ Nests objects in graduated size.
- _____ Builds a tower of 10 blocks.
- _____ Completes puzzle of 6-10/11-15 pieces.
- _____ Strings 1/2-inch beads.
- _____ Tears paper.
- _____ Folds paper.
- _____ Picks up small objects with pincer grasp.

Mailman Center for Child Development
(305) 243-6624

INDIVIDUAL EDUCATION PLAN:
INSTRUCTIONAL GOALS AND OBJECTIVES

Child's Name: ____________________________

Birth date: ______________________________

Center: _________________________________

36-42 MONTHS

Cognitive Development

- ____ Shows curiosity and desire to learn.
- ____ Recalls familiar objects.
- ____ Counts to 3 by rote.
- ____ Points to "different" when given two alike and one different.
- ____ Classifies objects by category.
- ____ Sorts cubes of two different colors.
- ____ Matches lotto pictures.
- ____ Understands three prepositions.
- ____ Returns materials to proper place.

SIGNATURES: ____________________ **(Parent)** ____________________ **(Teacher)**

Date: ___________________________

Mailman Center for Child Development
(305) 243-6624

INDIVIDUAL EDUCATION PLAN:
INSTRUCTIONAL GOALS AND OBJECTIVES

Child's Name: ______________________

Birth date: ______________________

Center: ______________________

36-42 MONTHS

Gross Motor Development

- ____ Jumps down from low object.
- ____ Throws a ball a distance of at least 2 yards.
- ____ Catches a 6-to8-inch ball using arms.
- ____ Makes wide turns around obstacles while running and /or riding a tricycle.
- ____ Walks alone.
- ____ Jumps in place.
- ____ Walks up and down steps.

INDIVIDUAL EDUCATION PLAN:
INSTRUCTIONAL GOALS AND OBJECTIVES

Child's Name: ______________________________

Birth date: ________________________________

Center: ___________________________________

42-48 MONTHS

Gross Motor Development

- ____ Walks up and down stairs, one foot per step, without rail or adult assistance.
- ____ Balances on one foot for 4 to 5 seconds.
- ____ Throws a ball overhanded and underhanded for a distance of at least 2 yards.
- ____ Climbs up and down equipment without falling
- ____ Throws an object in the intended direction.
- ____ Runs with control over direction and speed.
- ____ Shows balance in use of large muscles.
- ____ Walks backward/sideways.
- ____ Walks on tip toe four to five steps.
- ____ Hops on one foot.

Mailman Center for Child Development
(305) 243-6624

INDIVIDUAL EDUCATION PLAN:
INSTRUCTIONAL GOALS AND OBJECTIVES

Child's Name: ______________________________
Birth date: ________________________________
Center: ___________________________________

36-42 MONTHS

Personal Awareness Development

- ❖ ____ Wipes won nose with tissue.
- ❖ ____ Removes clothes for toileting.
- ❖ ____ Pours from pitcher with little or no spilling.
- ❖ ____ Unbuttons front button- large size (3/4-inch or larger).
- ❖ ____ Willing to taste food provided at lunch or snack time.
- ❖ ____ Drinks from cup.
- ❖ ____ Uses spoon/fork.
- ❖ ____ Removes socks/shoes.
- ❖ ____ Indicates toilet needs.
- ❖ ____ Washes hands/ dries hands.
- ❖ ____ Works alone during an activity.
- ❖ ____ Helps put materials away.

INDIVIDUAL EDUCATION PLAN:
INSTRUCTIONAL GOALS AND OBJECTIVES

Child's Name: ____________________________

Birth date: ____________________________

Center: ____________________________

42-48 MONTHS

Personal Awareness Development

- ____ Uses spoon/fork.
- ____ Uses napkin.
- ____ Wipes up spills.
- ____ Serves own plate unassisted.
- ____ Unsnaps/ unbuttons/ unzips clothing.
- ____ Removes shirt/ pants/ dress.
- ____ Puts on shoe/ socks.
- ____ Dresses independently.
- ____ Washes face/ dries face.
- ____ Turns faucet on and off.
- ____ Brushes teeth.
- ____ Remembers to flush toilet with out reminder.

Mailman Center for Child Development
(305) 243-6624

Internal Referral/Follow up Form

-Mailman Center for Child Development-

Fax (305) 243-3410

Child's Name: ____________________

Date of Birth: ____________________

ChildCare Center: ____________________

Address: ____________________

REFERRAL

TO: ____________________

FROM: ____________________

Description of problem:

Signature: ____________________

FOLLOW-UP

Follow-up completed by: ____________________ **Date:** __________

DOC
TYPE 4140

DADE COUNTY PUBLIC SCHOOLS
OFFICE OF EXCEPTIONAL STUDENT EDUCATION

PRINT STUDENT'S NAME (LAST) (FIRST) (M.I.)	
DATE (MM/DD/YY)	
STUDENT ID. NO.	

OBSERVATION OF PREKINDERGARTEN STUDENT BEHAVIORS

Student's Name: ....

Observer: ....

Language Used: ....

Birthdate: ....

School: ....

Exceptionality: ....

Two observations are required. One must be done by the student's teacher; the other, by a second prekindergarten teacher, speech, occupational or physical therapist. If the child speaks a language other than English, one observation must be completed by a staff person who speaks the child's home language.

Never	**[0%]**
Sometimes	**[1 / 40%]**
Often	**[41 / 70%]**
Excessively	**[over 70%]**

I. ATTENDING BEHAVIORS	NEVER	SOMETIMES	OFTEN	EXCESSIVELY
Has difficulty staying in seat				
Does not complete tasks				
Has short attention span				
Is easily distracted				
Is lethargic				
Does not attend to task at hand				
Does not participate in large group activities				
Does not participate in small group activities				

Comments: ....

....

Attempted Remediations: ....

II. INTERPERSONAL BEHAVIORS	NEVER	SOMETIMES	OFTEN	EXCESSIVELY
Avoids eye contact				
Tries to dominate others				
Is overly dependent upon others				
Is socially withdrawn				
Prefers solitary activities				
Avoids interactive play				
Avoids communication with adults				
Avoids communication with peers				

FM-4140 Rev. (03-97)

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Never [0%]
Sometimes [1 / 40%]
Often [41 / 70%]
Excessively [over 70%]

I. INTERPERSONAL BEHAVIORS (Cont'd.)

	NEVER	SOMETIMES	OFTEN	EXCESSIVELY
Avoids interaction with other children				
Has difficulty sharing				
Is ignored by peers				
Is sexually aggressive towards other students				
Is physically aggressive (hits, kicks, bites, etc.)				

Comments: ....

....

Attempted Remediations: ....

II. DISRUPTIVE/INAPPROPRIATE BEHAVIORS

	NEVER	SOMETIMES	OFTEN	EXCESSIVELY
Exhibits rocking behavior				
Exhibits other perseverating (repetitious) behaviors: specify				
Has temper tantrums				
Exhibits self-injurious behavior: specify				
Lacks self-control				
Talks out inappropriately				
Appears hyperactive/overactive				
Cries inappropriately				
Demonstrates inappropriate mood changes				
Takes things belonging to others				
Makes untrue statements				
Is destructive (classroom materials, property, etc.)				

Comments: ....

....

Attempted Remediations: ....

V. INDICATORS OF ANXIETY

	NEVER	SOMETIMES	OFTEN	EXCESSIVELY
Is nervous, jumpy				
Tends to worry				
Seems unhappy				
Has difficulty with changes in routine				
Is fearful of peers				

Never [0%]
Sometimes [1 / 40%]
Often [41 / 70%]
Excessively [over 70%]

IV. INDICATORS OF ANXIETY (Cont'd.)

	NEVER	SOMETIMES	OFTEN	EXCESSIVELY
Is tense, seems unable to relax				
Is easily frustrated and confused				
Is self-conscious, easily embarrassed				
Has frequent toilet accidents in threatening situations				

Comments: ....

....

Attempted Remediations: ....

V. PSYCHO-PHYSIOLOGICAL

	NEVER	SOMETIMES	OFTEN	EXCESSIVELY
Uses bathroom excessively				
Complains of headaches				
Complains of stomachaches				
Rubs eyes, eyelids/eyes are inflamed				
Holds materials close to face				
Turns head to one side while listening or working				
Exhibits muscle spasms (twitches or ticks)				
Becomes ill when upset or frustrated				

Comments: ....

....

Attempted Remediations: ....

VI. SELF-CONCEPT

	NEVER	SOMETIMES	OFTEN	EXCESSIVELY
Lacks self-confidence				
Lacks motivation				
Needs inordinate amount of praise and encouragement				
Demands inordinate amount of attention from teacher				
Avoids challenging tasks				

Comments: ....

....

Attempted Remediations: ....

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Never [0%]
Sometimes [1 / 40%]
Often [41 / 70%]

VII. FOR SPEAKER(S) OF LANGUAGE(S) OTHER THAN ENGLISH

SOCIAL LANGUAGE BEHAVIORS

	NEVER	SOMETIMES	OFTEN
Distinguishes environmental sounds			
Points/names classroom items			
Understands classroom directions			
Exchanges common greetings			
Appropriately initiates, maintains and responds to a conversation			
Gives classroom commands to peers			
Orally participates in group activities			
Prefers to use/seems to better understand the home language			

ACADEMIC LANGUAGE BEHAVIORS

	NEVER	SOMETIMES	OFTEN
Follows specific directions for academic/cognitive tasks			
Understands vocabulary for academic/cognitive tasks			
Understands a simple story			
Asks/answers specific questions during group time activities			
Asks for clarification			
Volunteers to answer questions during teacher-initiated activities			
Understands connection between spoken and written language			
Follows along during oral reading activities			

Comments: ....

....

Attempted Remediations: ....

ASSESSMENT INSTRUMENT

CURRENT LEVELS OF DEVELOPMENT

Cognitive Skills - Age Level ____________

Strength ____________

Weakness ____________

Gross Motor Skills - Age Level ____________

Strength ____________

Weakness ____________

Fine Motor Skills - Age Level ____________

Strength ____________

Weakness ____________

Language/Communication Skills - Age Level ____________

Strength ____________

Weakness ____________

Social/Self-Help Skills - Age Level ____________

Strength ____________

Weakness ____________

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Based upon your experiences with this pupil, do you believe a discrepancy exists between this pupil's ability and his/her performance?

Why/Why not?

Recent environmental changes:

Attendance Record:

Teacher's Comments:

Teacher's Signature: Date:

Principal's Comments:

Principal's Signature: Date:

MIAMI-DADE COUNTY PUBLIC SCHOOLS
Division de Educación para Estudiantes Especiales

OBSERVACION DEL COMPORTAMIENTO DEL ESTUDIANTE DE PREKINDER

Nombre del Estudiante: ______________________ Fecha de Nacimiento: ______________

Observador: ______________________ Escuela: ______________________

Idioma Utilizado: ______________________ Fecha de la Observación: ______________________

Se requieren dos observaciones: Una debe ser efectuada por la maestra del estudiante, la otra por un terapeuta de lenguaje, otra maestra de Prekinder, terapeuta ocupacional, o terapeuta física. Si el niño habla otro idioma que no sea inglés, una observación debe ser efectuada por alguien del personal que hable el idioma del hogar del niño.

Nunca	(0%)
Algunas Veces	(1 al 40%)
Frecuentemente	(41 al 70%)
Excesivamente	(Más del 70%)

I. ATENCION	**NUNCA**	**ALGUNAS VECES**	**FRECUENTE-MENTE**	**EXCESIVA-MENTE**
1. Tiene dificultad para permanecer sentado en el asiento.				
2. No completa su tarea.				
3. Presta atención por muy poco tiempo.				
4. Se distrae fácilmente.				
5. Es aletargado (lento, soñoliento).				
6. No pone atención a la tarea que está haciendo.				
7. No participa en actividades en grupos grandes.				
8. No participa en actividades en grupos pequeños.				

COMENTARIOS: ____

____

Soluciones Intentadas: ____

____

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II. COMPORTAMIENTOS INTERPERSONALES	NUNCA	ALGUNAS VECES	FRECUENTEMENTE	EXCESIVAMENTE
1. Evita mirar cara a cara (mirar a los ojos).				
2. Trata de dominar a otros.				
3. Depende demasiado de los demás.				
4. Es retraído.				
5. Prefiere actividades solitarias.				
6. Evita los juegos de interacción con otros niños.				
7. Evita la comunicación con los adultos.				
8. Evita la comunicación con sus compañeros.				
9. Evita la interacción con otros niños.				
10. Tiene dificultades en compartir.				
11. Es ignorado por sus compañeros.				
12. Es agresivo sexualmente con otros niños.				
13. Es agresivo físicamente (pega, patea, muerde, etc.)				

COMENTARIOS: ______________________________

Soluciones Intentadas: ______________________________

III. COMPORTAMIENTOS INAPROPIADOS O QUE INTERRUMPEN AL GRUPO	NUNCA	ALGUNAS VECES	FRECUENTEMENTE	EXCESIVAMENTE
1. Se mece frecuentemente.				
2. Muestra otros comportamientos repetitivos: especifique:				
3. Le dan perretas (pataletas).				
4. Se hace daño a sí mismo.				
5. No tiene control de sí mismo.				
6. Habla inapropiadamente (fuera de lugar).				
7. Parece hiperactivo (demasiado activo).				
8. Llora inapropiadamente (sin motivo).				
9. Muestra cambios inapropiados de temperamento.				
10. Toma cosas que le pertenecen a otros.				
11. Dice mentiras.				
12. Es destructor (de los materiales de clase, juguetes, etc.).				

COMENTARIOS: ______________________________

Soluciones Intentadas: ______________________________

IV. INDICADORES DE ANSIEDAD	NUNCA	ALGUNAS VECES	FRECUENTE-MENTE	EXCESIVA-MENTE
1. Es nervioso. Se sobresalta.				
2. Tiende a preocuparse.				
3. Parece descontento, triste.				
4. Tiene dificultades cuando hay cambios de rutina.				
5. Le teme a sus compañeros.				
6. Está tenso, parece incapaz de relajarse.				
7. Se frustra y se confunde fácilmente.				
8. Se preocupa porque lo miran y se abochorna fácilmente.				
9. Tiene "accidentes" en su ropa cuando confronta situaciones difíciles (se orina, etc.).				

COMENTARIOS: ______________________________

Soluciones Intentadas: ______________________________

V. PSICO-FISIOLOGIA	NUNCA	ALGUNAS VECES	FECUENTE-MENTE	EXCESIVA-MENTE
1. Va al baño en exceso.				
2. Se queja de dolores de cabeza.				
3. Se queja de dolores de estómago.				
4. Se frota los ojos, tiene los párpados/ojos inflamados.				
5. Acerca materiales a la cara.				
6. Voltea la cabeza hacia un lado mientras escucha o trabaja.				
7. Le dan espasmos musculares (tics, o movimientos bruscos involuntarios).				
8. Se enferma cuando se enoja o se frustra.				

COMENTARIOS: ______________________________

Soluciones Intentadas: ______________________________

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VI. CONCEPTO DE SI MISMO	NUNCA	ALGUNAS VECES	FRECUENTEMENTE	EXCESIVAMENTE
1. Le falta confianza en sí mismo.				
2. Le falta motivación.				
3. Necesita demasiados elogios y estímulos.				
4. Exige demasiada atención de la maestra.				
5. Evita tareas que sean difíciles.				

COMENTARIOS: ____

____

Soluciones Intentadas: ____

____

VII. PARA QUIENES HABLAN OTRO IDIOMA QUE NO SEA INGLES	NUNCA	ALGUNAS VECES	CON FRECUENCIA
A. ASPECTO SOCIAL DEL LENGUAJE			
Distingue sonidos del medio ambiente.			
Señala/nombra objetos de la clase.			
Entiende instrucciones que se dan en la clase.			
Intercambia saludos.			
Inicia, mantiene, y responde a conversaciones apropiadamente.			
Da instrucciones a sus compañeros.			
Participa oralmente en actividades de grupo.			
Prefiere utilizar o parece entender mejor el idioma de la casa.			
B. ASPECTO ACADEMICO DEL LENGUAJE			
Sigue instrucciones específicas para tareas académicas.			
Entiende vocabulario para tareas académicas.			
Entiende historias sencillas.			
Pregunta/contesta preguntas específicas durante actividades de grupo.			
Pide aclaración (explicación).			
Se ofrece a contestar preguntas durante actividades iniciadas por la maestra.			
Entiende la conexión entre el lenguaje escrito y el lenguaje verbal.			
Puede entender las historias que escucha.			

COMENTARIOS: ____

____

Soluciones Intentadas: ____

____

Nombre de la prueba utilizada para evaluar al niño:

____

Destrezas Intelectuales (Pre-académicas)

Edad en la que está funcionando ____________________

Habilidades ____________________

Limitaciones ____________________

____

Destrezas Motoras (correr, caminar, saltar, etc.)

Edad en la que está funcionando ____________________

Habilidades ____________________

Limitaciones ____________________

____

Destrezas de Movimientos Finos (comer, agarrar, colorear, etc.)

Edad en la que está funcionando ____________________

Habilidades ____________________

Limitaciones ____________________

____

Destrezas de lenguaje/comunicación

Edad en la que está funcionando ____________________

Habilidades ____________________

Limitaciones ____________________

____

Destrezas Sociales y actividades del diario vivir (comer, vestirse, ir al baño, etc.)

Edad en la que está funcionando ____________________

Habilidades ____________________

Limitaciones ____________________

Basándose en su experiencia con este alumno, cree usted que existe una discrepancia entre las habilidades del alumno y su comportamiento?

Por qué/Por qué no? ____________________

____

Cambios recientes en su medio ambiente; su familia, etc. ____________________

____

Record de asistencia: ____________________

Comentarios de la maestra: ____________________

____

____

____

Firma de la maestra: ____________________ Fecha: ____________________

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Comentarios de la Coordinadora del Centro o Coordinadora Educacional: ______________________

Firma de la Coordinadora del Centro o Coordinadora Educacional: ______________________
Fecha: ______________

July 20, 1998/CAM

DADE COUNTY PUBLIC SCHOOLS
DIVISION OF EXCEPTIONAL STUDENT EDUCATION

FLORIDA DIAGNOSTIC AND LEARNING RESOURCES SYSTEM/SOUTH
5555 South West 93rd Avenue. Miami, Florida 33165
phone: (305) 274-3501 Fax: (305) 598-7752

Estimado padre:

Su hijo/a ha sido referido para determinar si necesita los servicios del programa para Niños Excepcionales de las Escuelas Públicas del Condado de Dade.

Le envío unas planillas para que usted las llene y las firme, ya que son necesarias para procesar el caso de su hijo/a.

Después de revisar la información sobre su hijo/a, determinaremos si su hijo/a será evaluado en el Centro de Diagnóstico de las Escuelas Públicas del Condado de Dade.

Si usted necesita más información, por favor llámeme al 274-3501.

Por favor, notifíquenos inmediatamente si cualquiera de los siguientes sucesos ocurre antes de que le demos una cita para evaluar a su hijo/a:

1. Su hijo/a comienza a asistir a una nueva escuela.
2. Su hijo/a recibe un examen médico por una enfermedad o accidente serio.
3. Su hijo/a recibe una evaluación psicológica, psiquiátrica, audiológica, o del habla.
4. Su hijo/a recibe tratamiento médico por un problema serio, tratamiento psicológico o psiquiátrico, terapia del habla, o terapia física u ocupacional.

Si usted no tiene transporte y su hijo/a recibe Medicaid, por favor llámenos (274-3501) para explicarle cómo solicitar **transporte de Medicaid.**

Gracias por su cooperación.

Atentamente,

Susana I Cossío

Susana Inclán Cossío, M.A., NCSP
Child Find Specialist

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FLORIDA DIAGNOSTIC AND LEARNING RESOURCES SYTEM-SOUTH (FDLRS-S)

CHILD FIND PROGRAM

NOMBRE DEL NINO: ____________________ FECHA DE NACIMIENTO: __________

DIRECCION: __________________________ LUGAR DE NACIMIENTO: __________

TELEFONO: ____________________ TELEFONO DEL TRABAJO: ______________

CUESTIONARIO

1. MIEMBROS DE FAMILIA

1. Nombre de la madre ______________________________
   Edad de la madre ______________________________
   Empleo de la madre ______________________________
   Donde trabaja la madre ______________________________
   Lugar de nacimiento de la madre ______________________________

2. Nomre del padre ______________________________
   Edad del padre ______________________________
   Empleo del padre ______________________________
   Donde trabaja el padre ______________________________
   Lugar de nacimiento del padre ______________________________

3. Fecha de matrimonio ______________________________
   Lugar de matrimonio ______________________________
   ? Estuvieron casados antes? ______________________________
   Si es asi, cuando? ______________________________
   ? Tuvieron hijos? ______________________________
   ? Cuantos anos tienen? ______________________________
   ? Tienen algun problema?, explique ______________________________
   ____
   ____

4. ? Que idioma se habla en la casa? ______________________________

- atras -

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5. Nombre y edades de sus hijos______________________________
____

? Hay alguno en educacion especial?___________________________
____

? Tienen algun otro problema?_________________________________
____

II. ESTADO DE GESTACION DE LA MADRE (por el hijo que necesita nuestros servicios)

1. ? Estuvo usted bajo el cuidado de un doctor?____________

2. ? Tomo usted alguna medicacion, o alguna droga?, Cuales
____

3. ? Fumaba usted?_______? Cuanto?________________________

4. ? Tuvo usted algun problema durante su estado de gestacion? explique____
____

5. ? Fue su parto prematuro o a los nueve meses?___________
Si fue prematuro, ? en que mes?_________________________

6. ? Tiene alguna historia medica de enfermedad el padre o la madre?____
____

7. ? Fue el parto normal o cesarea?________________________

8. Peso de nacimiento__________libras______________onzas

9. ? Tuvo el nino o nina algun problema antes, en, o despues del nacimiento?______________________________
____

III. HISTORIA DEL CRECIMIENTO

1. ? A que edad el/ella se sento solo?____________________

2. ? A que edad camino?____________________

3. ? A que edad fue al bano solo?____________________

4. ? Se orina en la cama?____________________

5. ? Cuando dijo su primera palabra?____________________

6. ? Cuando el/ella dijo una frase?____________________

7. ? Pueden otras personas entenderlo claramente?__________

8. ? Cuando su hijo/hija comio solo con una cuchara?______
____

9. ? Su hijo/hija se viste solo?____________________

10. ? Tiene su hijo/hija algun problema para dormirse o alimentarse?____________________
Por favor explique____________________
____

IV. HISTORIA MEDICA

1. ? Ha estado su hijo/hija hospitalizado?____________________
Si es asi, explique cuando y por que____________________
____
____

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2. ? Ha tenido el/ella alguna operacion sin haber estado hospitalizado?____

3. ? Tiene su hijo/hija epilepsia?____
Si es asi, explique____

4. ? Tiene su hijo/hija alguna enfermedad?____
Si es asi, explique____

5. ? Esta su hijo/hija tomando algun medicamento?____
? Cual es el nombre de la medicina?____

6. ? Necesita su hijo usar algun equipo especial?____
Por favor, explique____

7. ? Tiene su hijo/hija problemas del oido, o problemas auditivos?____Explique____

8. ? Tiene su hijo/hija problemas en los ojos?____
Si es asi, explique____

? Usa su hijo espejuelos?____

9. ? Necesita su hijo/hija zapatos especiales?____
Si es asi, ? por que?____

10. ? Tiene su hijo/hija algun problema medico no mencionado ya?____explique____

11. ? Recibe su hijo/hija terapia del habla, terapia fisica o terapia de las manos?____
Si es asi, explique____

12. Nombre y direccion del terapista____

V. HISTORIA EDUCACIONAL

1. ? Esta su hijo/hija asistiendo a una escuela pre-escolar en la actualidad?____________________
Nombre y direccion de la escuela____________________
____
Numero de telefono____________________
? Ha asistido antes a otra escuela____________________

2. ? Ha tenido su hijo/hija algun problema en el programa escolar ha estado asistiendo? explique____________________
____

3. ? Puede su hijo/hija separarse facilmente de usted?____
____

? Como cree usted que su hijo/hija aprende mejor?______
____

VI COMPORTAMIENTO EN LA ACTUALIDAD

1. ? Cual es la actividad favorita de su hijo/hija en la casa?____________________

2. ? Por que tiempo el/ella permanece en una sola actividad
____

3. ? Tiene el/ella alguna obligacion en la casa?__________
____

4. ? Tiene el/ella alguna dificultad para tratar algun miembro de la familia?____________________
Si es asi, explique____________________
____

5. ? Que tipo de disciplina usa usted con su hijo?__________
____
? Tiene exito?____________________

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6. ? Hay algun problema familiar afectando a su hijo/hija?__
Si es asi, explique____

7. ? Puede su hijo/hija seguir instrucciones verbales?______

8. ? Que hace su hijo/hija cuando se pone bravo?____

9. ? Cuales son las causas que hacen su hijo llorar?____

10. ? Cuales son las cosas que hacen a su hijo/hija sentirse contento?____

11. ? Piensa usted que su hijo\hija tiene algun problema de comportamiento o emocional?___________________________
Describalo_______________________________________
? Cuando comenzo el problema? _____________________

VII. COMENTARIO DE LOS PADRES

1. ? Como usted describiria a su hijo/hija?____

2. ? Ha tenido su hijo/hija algun cambio recientemente en su comportamiento? , explique____

3. ? Hay algun prolema no mencionado antes que usted crea que nosotros deberiamos de saber?, explique____

Este cuestionario ha sido llenado por __________________________
el_____________________________(fecha)
Parentesco con el nino/nina______________________________________

DADE COUNTY PUBLIC SCHOOLS
DIVISION OF EXCEPTIONAL STUDENT EDUCATION

FLORIDA DIAGNOSTIC AND LEARNING RESOURCES SYSTEM/SOUTH
5555 South West 93rd Avenue. Miami, Florida 33165
phone: (305) 274-3501 Fax: (305) 598-7752

Estimado Padre:

Le adjuntamos una Carta de Consentimiento para Intercambiar Información para que escriba en ella los nombres de todas las personas y organizaciones que han trabajado con su hijo/a. Estas incluyen:

1. Médicos (ejemplo: pediatra, neurólogo, psiquiatra, especialista de garganta, nariz y oído, oculista, ortopédico, especialista en genética, etc.). Por favor, escriba la especialidad de cada médico al lado de su nombre.

2. Otros especialistas (ejemplo: psicólogo, audiólogo, patólogo o terapista del habla, terapista físico u ocupacional, optometrista, etc.) Por favor, escriba la especialidad de la persona al lado de su nombre.

3. Hospitales y clínicas.

4. Centros para Diagnóstico y Tratamiento (ejemplo: Mailman Center for Child Development, Easter Seal, United Cerebral Palsy, Association for Retarded Citizens, Debbie School, etc.)

5. Escuelas (públicas y privadas); "Day Care Centers" (centros donde cuidan niños.)

Por favor, firme la planilla para que podamos intercambiar información con las personas y organizaciones que usted ha mencionado, para así poder ayudar a su hijo/a.

Gracias por su cooperación.

Atentamente,

Susana I Cossío

Susana Inclán Cossío, M.A., NCSP
Child Find Specialist

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ESCUELAS PUBLICAS DEL CONDADO DE DADE
(DADE COUNTY PUBLIC SCHOOLS)
Office of Exceptional Student Education

CARTA DE CONSENTIMIENTO PARA EL INTERCAMBIO MUTUO DE INFORMACIÓN (CONSENT FORM FOR MUTUAL EXCHANGE OF INFORMATION)

Fecha ____________________

Nombre del estudiante ____

Fecha de nacimiento ______________________ No. de Ident. __________

Con la presente carta autorizo el intercambio de información en referencia a mi hijo, ____________, entre las Escuelas Publicas del Condado de Dade y las siguientes agencias (incluyendo escuelas, médicos, sicólogos, hospitales, clinicas, etc., que han tenido que ver con su hijo/hija).

Nombre	Dirección

- Los documentos especificos divulgados conciernén: ______________________
- La razón de tener estos documentos disponibles es: ______________________
- La(s) persona(s) que reciban estos documentos no divulgaran la información con otras personas y/o agencias sin su consentimiento.

Hago constar que soy el padre o tutor legal del niño cuyo nombre, se menciona arriba o que soy un estudiante mayor de edad y estoy autorizado para firmar esta carta de autorización.

Nombre ____________________ Firma ____________________

Dirección ____________ Ciudad, Estado ____________ Codigo Postal ____________

Sirvase devolver esta carta a:
FDLRS SOUTH-CHILD FIND DEPT
5555 S.W. 93rd Ave
Miami, Florida 33165

FM-2120S Rev. (12-94)

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FDLRS/SOUTH
Florida Diagnostic & Learning Resources System/South
Dade County Public Schools
Exceptional Student Education
5555 S.W. 93 Avenue, Miami, FL 33165
(305) 274-3501 • Fax (305) 598-7752 • W.L. #9618

FDLRS/South CHILD FIND

IDIOMA QUE SE HABLA EN EL HOGAR

NOMBRE DEL NIÑO: ______________________ FECHA: __________

Por favor, responda las siguientes preguntas:

1) ¿En su hogar se habla algún idioma además del inglés?

Sí ________ No ________

2) ¿El primer idioma que el estudiante utilizó fue un idioma que no es el inglés?

Sí ________ No ________

3) ¿El idioma que el estudiante habla con mayor frecuencia es un idioma que no es el inglés?

Sí ________ No ________

¿Qué idiomas habla la madre? ______________________________

¿Qué idiomas habla el padre? ______________________________

¿Qué idiomas hablan otras personas que viven en la casa o que cuidan al niño(a)? ________

____

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MIAMI-DADE COUNTY PUBLIC SCHOOLS
DIVISION OF EXCEPTIONAL STUDENT EDUCATION

FLORIDA DIAGNOSTIC AND LEARNING RESOURCES SYSTEM/SOUTH
5555 South West 93rd Avenue Miami, Florida 33165
Phone: (305) 274-3501 Fax: (305) 598-7752

Dear Parent:

Your child has been referred to us for possible placement within Miami-Dade County Public Schools Exceptional Student Education Program.

Enclosed you will find some forms to fill out and sign. We must have these forms back right away in order to process your child's case.

Once we have gathered and reviewed all the information, we will determine whether your child will be scheduled at the Florida Diagnostic and Learning Resources System/South for a screening or an evaluation.

If you need further assistance, please call my staff at (305) 274-3501.

Please, notify us immediately if between now and the time that we give your child an appointment any of the following events takes place:

1. Your child begins to attend a new school.
2. Your child receives a medical evaluation for a major illness or accident.
3. Your child receives psychological, psychiatric, speech/language, and/or audiological evaluations.
4. Your child receives medical treatment for a major problem, psychotherapy, psychiatric treatment, speech/language therapy and/or physical/occupational therapy.

Thank you for your cooperation.

Sincerely,

Susana I Cossío

Susana Inclán Cossío, M.A., NCSP
Child Find Specialist

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FDLRS/South

FLORIDA DIAGNOSTIC AND LEARNING RESOURCES SYSTEM/SOUTH
Miami-Dade County Public Schools
55 S.W. 93rd Avenue; Miami, FL 33165
305/274-3501; FAX: 305/598-7752
Child Find Office

CHILD/FAMILY QUESTIONNAIRE

Name of Child____________________ Sex:_______ Date of Birth______________

Home Telephone____________________ Place of Birth______________

Home Address____________________ City:__________ Zip Code__________

Name of Parent or Guardian with whom Child lives____________________

FAMILY MEMBERS

Mother's Name____________________ Birthplace__________ Age_____

Mother's Job____________________ Home Phone______________

Work Place____________________ Work Phone______________

ather's Name____________________ Birthplace__________ Age_____

Father's Job____________________ Home Phone______________

Work Place____________________ Work Phone______________

What language(s) is/are spoken in the home?____________________

What adults live in the child's home?____________________

____

List names and ages of all children in the present family____________________

____

Do any live in another home? If yes, with whom?____________________

____

Are any in special education?____________________

Do they have any other problems?____________________

Are there any children from another relationship?__________ If yes, how old are they?______________

they have any problems?_______ If yes, describe____________________

____

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MEDICAL HISTORY (continued)

Does your child take daily medication?________If yes, give name and dosage of medicine, and the reason for taking it:___

____

____

____

Does your child require special equipment, such as a wheelchair, braces, etc.?__________If yes, explain_______________

____

Does your child have ear or hearing problems?________If yes, explain____

____

Does your child have eye problems?__________If yes, explain____

____Does s/he wear glasses?__________________________

Does your child need special shoes?__________If yes, why?____

____

Does your child have any special condition not yet mentioned?___________________________________

If yes, explain____

Is your child receiving speech therapy, physical therapy, or occupational therapy?______________________

If yes, explain____

EDUCATION HISTORY

Is your child attending a day care, nursery, or school program?______________If yes, where?________________

____Phone__________________

Has your child ever attended another before?____________________________When?_______________

Are there any problems your child has had in either of the above program(s)?______________________

____

____

Can your child separate easily from you?____

How do you feel your child learns best?____

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MIAMI-DADE COUNTY PUBLIC SCHOOLS
DIVISION OF EXCEPTIONAL STUDENT EDUCATION
FLORIDA DIAGNOSTIC AND LEARNING RESOURCES SYSTEM/SOUTH
5555 South West 93rd Avenue Miami, Florida 33165
Phone: (305) 274-3501 Fax: (305) 598-7752

Dear Parent:

On the attached Consent Form for Mutual Exchange of Information, please list all persons, agencies and organizations that have worked with your child. These include:

1. Medical doctors (ex: pediatrician, neurologist, psychiatrist, ear-nose-throat specialist, ophthalmologist (eye doctor), orthopedist, geneticist, etc.) Please state each doctor's specialty beside his/her name.

2. Other specialists (ex: psychologist, audiologist, speech/language pathologist, occupational and physical therapists, optometrist, etc.) Please state each person's specialty beside his/her name.

3. Hospitals and clinics.

4. Diagnostic and treatment centers or agencies (ex: Mailman Center for Child Development, Easter Seal, United Cerebral Palsy, Association for Retarded Citizens, Debbie School, etc.)

5. Day care centers and schools (public and private).

Please sign the form so that we may exchange information with those whom you have listed in order to better help your child.

Thank you for your cooperation.

Sincerely,

Susana I Cossío

Susana Inclán Cossío, M.A., NCSP
Child Find Specialist

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MIAMI-DADE COUNTY PUBLIC SCHOOLS
Office of Exceptional Student Education

CONSENT FORM FOR MUTUAL EXCHANGE OF INFORMATION

Date____________________

Student's Name____

Date of Birth ____________________ ID#____________________

I hereby authorize the mutual exchange of records pertaining to my child, ____________________, between the MIAMI-DADE COUNTY PUBLIC SCHOOLS and the following agencies (include all schools, physicians, psychologists, hospitals, clinics, etc., that have had significant contact with your child):

Name/Specialty	Address/Phone

- The specific records to be disclosed pertain to:____
- The purpose for making these records available is:____
- The receiving party will not disclose the information to any other parties without signed consent.

I certify that I am the parent or legal guardian of the child named above or that I am the student of majority age and have the authority to sign this release.

____________________ ____________________

Name Printed Signature

____

Address City, State Zip Code

Please return this form to:

FDLRS/South – Child Find Office
5555 S. W. 93rd Avenue
Miami, Florida 33165

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FDLRS-SOUTH

Florida Diagnostic & Learning Resources System – South
Exceptional Student Education, Miami-Dade County Public Schools
5555 S.W. 93 Avenue, Miami, FL 33165 • M-DCPS W.L. #9618
(305) 274-3501 • Fax (305) 598-7752

HOME LANGUAGE SURVEY

Date: ______

Child's Name: ____ **Birthdate:** ______
First Middle Last

Please answer the questions below:

1. **Is a language other than English used in the home?** Yes ________ No ________
2. **Did the student have a first language other than English?** Yes ________ No ________
3. **Does the student most frequently speak a language other than English?** Yes ________ No ________

Language/s spoken by Mother: ________________________________

Language/s spoken by Father: ________________________________

Language/s spoken by other Caretakers: __________________________

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Mailman Center for Child Development
Fax (305) 243-3410

DENIAL OF CONSENT FOR SERVICES

As parent or legal guardian of --

Center --

It is my desire that services not be provided to my child by MCCD. I understand that this service has been recommended and that it will be provided free-of-charge. I accept the consequences of this action and in no way hold Mailman Center for Child Development responsible for any future problems resulting from lack of service.

Please print name: --------------------

Signature: ------------------------------

Date: ------------------------------------

Witnessed by:

Name: -----------------------------------

Signature: ----------------------------

Date: ------------------------------------

REFERRAL FOR ASSESSMENT

SCHOOL'S NAME:
ADDRESS: **PHONE:**

CHILD'S NAME: **DOB:** **CA:**
TEACHER'S NAME: **DATE OF REFERRAL:**

Reason for Referral:

Presenting Problem:

Recent traumatic events:

Siblings (if special needs, please indicate):

Description of child's verbal abilities:

Description of child's cognitive abilities:

Description of child's motor development/skills:

Description of child's social/emotional development/skills:

Additional comments:

SPECIAL INSTRUCTION CONSULTANT
SERVICE PLAN

CHILD'S NAME:________________ D.O.B________ Gender________
C.A. ________

Center:____________________

Teacher's name:____________________ DATE:______________

GOALS:____

OBJECTIVES:____

STRATEGIES/MANAGEMENT NEEDS:

RELATED SERVICES: ________________________________
(information,frequency)

DATE OF MEETING:__________________

Teacher's name	Consultant's name Mailman Center	Parent/Guardian's

STAFF/PARENT CONSULTATION REPORT

CENTER:______________________________ DATE: ________________
STAFF'S NAME:________________________

CHILD'S NAME:________________________ D.O.B.______ C.A.______

PARENT/GUARDIAN'S NAME:______________________ TEL: ___________

PURPOSE:

COMMENTS:

RECOMMENDATIONS:

PARTICIPANTS:

PARENT/GUARDIAN'S	STAFF	CONSULTANT- SIC MAILMAN CENTER

STAFF/PARENT CONSULTATION REPORT

CENTER:______________________________ DATE: ________________
STAFF'S NAME:________________________

CHILD'S NAME:________________________ D.O.B.______ C.A.______

PARENT/GUARDIAN'S NAME:________________________ TEL: __________

PURPOSE:

COMMENTS:

RECOMMENDATIONS:

PARTICIPANTS:

________________________ ________________ ____________________
PARENT/GUARDIAN'S STAFF CONSULTANT- SIC
MAILMAN CENTER

Teacher's Name

Special Instruction Consultant's Name

Teacher's List of Children with Potential Special Needs

Please write the names of the children you are concerned about. Include their date of birth and any additional comments you want to add (e.g. child receives therapy services, child has been diagnosed with a disability).

❖
❖
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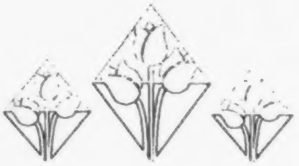
❖

Note: we must have a signed parent consent form before we can observe the child in the classroom



Community Resources

Helpful Information

Mailman Center for Child Development
1601 N.W. 12th Avenue
Miami, Fl 33136
(305) 243-6624
(305) 243-3410 Fax

Hearing and Speech Center of Florida
2511 Ponce de Leon Blvd, Suite 203
Coral Gables, Fl 33134
(305) 446-5597
(305) 448-0235 fax

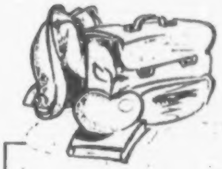
Miami Feeding and Speech Clinic
10700 Caribbean Blvd. Suite 211
Miami, Fl 33189
(786) 242-0886
(786) 242-9731 fax

Family Counseling Services
10700 Caribbean Blvd. Suite 207
Miami, Fl 33189
(305) 232-1610
(305) 238-5054 fax

Florida Diagnostic and Learning Resources System/South
5555 South West 93rd Avenue
Miami, Fl 33165
(305) 274-3501
(305) 598-7752 fax

COMMUNITY RESOURCE GUIDE

2002



FDLRS – SOUTH

Florida Diagnostic & Learning Resources System-South

Exceptional Student Education
5555 SW 93 Avenue, Miami, Florida 33165
(305) 274-3501 Fax (305) 598-7752

FDLRS-SOUTH, Monroe County

1400 United Street, Building A, Key West, Fl 33040
(305) 293-1646 Fax (305) 293-1485

http://fdlrs-south.dade.k12.fl.us

THE 2002 SCHOOL BOARD
OF
MIAMI-DADE COUNTY, FLORIDA

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http://fdlrs-south.dade.k12.fl.us

2002
MONROE COUNTY PUBLIC SCHOOLS

Michael Lannon
Superintendent of Monroe County Public Schools
Douglas E. Sayre
Director, Exceptional Student Education
Monroe County Schools Administration Building
1400 United Street
Key West, Florida 33040
(305) 293-1646 FAX (305) 293-1485

COMMUNITY RESOURCE GUIDE

2002

For Families and Caregivers of Students with Special Needs

FDLRS/SOUTH
Florida Diagnostic and Learning Resources System South
Exceptional Student Education, Miami-Dade County Public Schools

Alina C. Diaz, J.D.
Instructional Supervisor
5555 S.W. 93 Avenue
Miami, FL 33165
(305) 274-3501; Fax: (305) 598-7752
http://fdlrs-south.dade.k12.fl.us

FDLRS/South-Monroe County
Douglas Sayre
ESE Director
1400 United Street
Key West, FL 33040
(305) 293-1646; Fax: (305) 293-1485
http://www.monroe.k12.fl.us/

UPDATE INFORMATION

Updated information for the 2002 *Community Resource Guide* was compiled, proofread and entered by the following persons:

Carole F. Abbott, Ph.D., Child Find Outreach Specialist
Patricia Apeland, Assistant Instructional Technology Specialist
Marina Diaz, Preschool Outreach Screening Specialist
Eyra M. Quintana, Preschool Outreach Staff

The information contained on the **NICHCY/Florida State Resources** pages was current as of August 31, 2001. The information contained on the **NICHCY/National Resources** and **National Toll Free Numbers** pages was current as of August 31, 2001. All other information contained in the ***Community Resource Guide*** was accurate as of August 31, 2001.

PLEASE NOTE: The entire ***Community Resource Guide*** is downloadable in PDF format from the FDLRS/South website at **http://fdlrs-south.dade.k12.fl.us**. You will need ***Adobe Acrobat Reader***, which is available for free download at **http://www.adobe.com/acrobat**.

To the users of this guide:

PLEASE SEND ANY CORRECTIONS OR ADDITIONS TO: Eyra M. Quintana, FDLRS-South, 5555 SW 93rd Avenue, Miami, Florida 33165; (305) 274-3501; Fax (305) 598-7752; E-mail: eyra@fdlrs-south.dade.k12.fl.us

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Accessing Resources for Families of Children with Disabilities:

ACTT
Action for Children and Families Through Teaming

Free Information
Información Gratis
Enfòmasyon Gratis

Free Information and Help for Families of Children with Special Needs

CHILD FIND
Finds That Special Child

PARENT TO PARENT OF MIAMI

DEPARTMENT OF HUMAN SERVICES
DHS
"Love Your Neighbor"

CCDH
COMMUNITY COMMITTEE FOR DEVELOPMENTAL HANDICAPS

Distributed by:

ACTT
Action for Children and Families Through Teaming

Located at:

Florida Diagnostic & Learning Resources System/South (FDLRS/South)

5555 S.W. 93 Avenue
Miami, FL 33165
(305) 274-3501 **FAX** (305) 598-7752
http://fdlrs-south.dade.k12.fl.us

English * Kreyol * Español

For Free Help

Child Find

Locates and identifies individuals, ages birth through 22, who may have disabilities and who may need special education services. Disabilities may be present in the areas of vision, hearing, physical condition, behavioral/emotional adjustment, speech/ language, learning and intellectual development.

For children under 3 years of age
In the North call: (305) 243-5600
In the South call: (786) 268-2611

For children ages 3 years and older
Call: (305) 274-3501

Parent to Parent of Miami

Offers to parents of children with special needs, the following services free of charge:

- Information
- Support
- Advocacy
- Education

Call: (305) 271-9797

Central Directory

CCDH'S *Central Directory Project* is part of the Florida Directory of Early Childhood Services' statewide computerized resource and referral system. Our family-friendly Resource Specialists can provide information about a wide range of services in our community available to both children and adults with disabilities, including:

- Diagnosis and Evaluation
- Early Intervention Programs
- Therapies
- Support Groups
- Counseling, much more...

Call: (305) 596-1160

Child Care Resource and Referral Information

Provides resource and referral information on:

- Help in selecting and paying for child care/subsidized child care
- Before and after school, and summer programs
- Information on family support services
- Consumer education activities

Call: North – Hialeah, Opa Locka and North East areas call:
Family Central (305) 908-7300

South – All other areas call:
Miami – Dade Child Development Services (305) 373-3521

Sèvis Gratis Pou Ede

Nap Chachè

Nap Chachè è identifye timoun laj fek-fèt juska 22, ki ka ginyin dèsabilitè è ki ka beswin edikasyòn espesyal. Dèsabilitè-a kap non: wè, tandè, kondisyon fisikal, jan timoun nan agi, ajusman emosyonel, lang, jan li apran, è devlopman intelektyl.

Pou timoun pi piti kè 3 ans

Nan Nour Rèlè:	**(305) 243-5600**
Nan Sud Rèlè:	**(786) 268-2611**

Pou timoun 3 ans è plu gwen

Rèlè: (305) 274-3501

Paran Pou Paran Nan Miami

Paran ki gen timoun ki bezwen atansyon espesyal a ofri sefiès sa yo grantis:

- Enfòmasyon
- Sipò Moral
- Ede-w defan dwa w
- Ede-w nan zafe lekòl

Rèlè: (305) 271-9797

Direktè Santwal

CCDH's direktori pwojè Santwal sè yon pati dè direktori nan sèvis pou timoun piti resous konpitè nan gran eta è sistem referal. Fanmi-yan mi nov resous espesyalis kab ba-w enfòmasyon dè plusiè varietè dè sèvis nan komunitè-a ki la pou ni timoun ni granmoun ki ginyin dèsabilitè nan:

- Terapi
- GwupSupo
- Pwogwam Intevensyon Davans
- Dianosis è Evaluasyon
- Konsey, è plus...

Rèlè: (305) 596-1160

Sèvis Referanse Enfòmasyon sou Pwogwam Pou okipè Timoun

Sèvis sosyal pou timoun bay mwayen è bay enfòmasyon:

- Ed pou pèyè okipè timoun, seleksyon pwogwam pou timoun
- Siveyans pou elèv avan è Apre lekòl, pwogwam pou ètè
- Enfòmasyon pou Sèvis Supò pou Parent
- Aktivitè Edikasyòn pou Konsumè

Rèlè:

Nor - Hialeah, Opa Locka è Nan Nordwès Areya Rèlè:
Family Central (305) 908-7300

Sud – Tout Lot Areya Rèlè:
Miami-Dade Sant Devlopman Timoun (305) 373-3521

Para Ayuda Gratis

Child Find

Identifica personas desde que nacen hasta la edad de 22 años que pudieran tener algún impedimento y que pudieran necesiatr servicios de educación especial. Los impedimentos pudieran ser visuales, auditivos, físicos, emocionales ó de conducta, del habla y lenguaje, del aprendizaje ó de retrazo en el desarrollo intelectual.

Para niños menores de 3 años

En el Norte llamar al:	**(305) 243-5600**
En el Sur llamar al:	**(786) 268-2611**

Para niños mayores de 3 años

Llamar al: (305) 274-3501

De Padre a Padre de Miami

Padres de niños con necesidades especiales proveen ayuda gratis brindando:

- Apoyo
- Información
- Orientación
- Educación

Llamar al: (305) 271-9797

Directorio Central

El Directorio Central de CCDH, el cual forma parte del Directorio Central Servicios para niños pre-escolares, es un sistema computarizado que provee información. Nuestros amables especialistas proveen información acerca de una gran variedad de servicios disponibles a niños y adultos con incapacidades:

- Diagnóstico y Evaluación
- Programas de Intervernción Temprana
- Terapias
- Grupos de Apoyo
- Consejería y mucho mas…

Llamar al: (305) 596-1160

Información Sobre Recursos Para el Cuidado de Niños

Provee información sobre programas de cuidado infantil:

- Gaurderías a bajo costo y selección de Guarderías
- Programas para antes y después de la escuela, y programas de verano
- Información de servicios de apoyo familiar
- Actividades para la educación del consumidor

Llamar al: Norte - Hialeah, Opa Locka y el área del Este Norte:
Family Central (305) 908-7300

Sur - Todas las otras áreas:
Miami – Dade Child Development Services (305) 373-3521

INFANT SERVICES,
IDENTIFICATION & EARLY INTERVENTION

For free screening and evaluation of children suspected of having a developmental delay or disability call:

For children ages birth to 3 years:

Part C EARLY INTERVENTION PROGRAM (EIP)

North:
University of Miami/Mailman Center for Child Development
(305) 243-5600

South:
Miami Children's Hospital – Kendall Annex
(786) 268-2611

For children ages 3 through 22 years:

Child Find - FDLRS/South
(305) 274-3501

Other identification and early intervention services:

Early Head Start
Community Action Agency (CAA)
(305) 694-8477
(Registration Office-Holy Redeemer)

Family Healthline
(800) 451-Baby
(All calls are confidential. Counselors are available to answer questions regarding prenatal care, infant health care, family planning and drug and alcohol abuse.)

Healthy Start Service Program Office
(305) 278-0333
(Services for pregnant women and children to age three.)

Mount Sinai Developmental Evaluation Center
(305) 674-2630; Fax (305) 535-7915
4300 Alton Road
Miami Beach, Fl 33140

Women, Infants & Children
(WIC)
(305) 377-5656
(Special food and nutrition education program for Women, Infants & Children. Provides free food, nutrition counseling, breasts feeding support and health care referrals.)

(See also pp 7-9, **Early Care and Education Programs for Prekindergarten Children with Special Needs)**

SERVICE & RESOURCE AGENCIES ACCORDING TO EXCEPTIONALITIES

Miami-Dade County Public Schools Programs:

FOR INFORMATION ON THE FOLLOWING PROGRAMS CALL

OFFICE OF EXCEPTIONAL STUDENT EDUCATION

(305) 995-1721

Autism
Emotionally Handicapped
Gifted
Deaf or Hard of Hearing
Learning Disabled
Mentally Handicapped
Physically Impaired
Pre-Kindergarten Disabilities
Psychological Services
Severely Emotionally Disturbed
Speech/Language Impaired
Traumatic Brain Injured
Visually Impaired

OR

FDLRS-South at (305) 274-3501

OR

Region I	Office at (305) 687-6565
Region II	Office at (305) 624-8802
Region III	Office at (305) 883-0403
Region IV	Office at (305) 642-7555
Region V	Office at (305) 595-7022
Region VI	Office at (305) 246-5934

SERVICE & RESOURCE AGENCIES ACCORDING TO EXCEPTIONALITIES

Options for PreKindergarten Children with Special Needs

Child Care Resource & Referral Information

Child Development Services (CDS)
Hot Line: (305) 373-3521
Phone: (305) 633-6481
(Miami-Dade Department of Human Services/ Child Development Services and Family Central provide resource and referral information on: Help in selecting and paying for child care/subsidized child care; before & after school, and summer programs; information on family support services; consumer education activities.)

Family Central, Inc.
15910 N.W. 57th Avenue
Miami Lakes, FL. 33014
Phone: (305) 908-7300
Fax: (305) 908-7337

840 S.W. 81st Avenue
N. Lauderdale, FL. 33068
Phone: (954) 720-1000
Fax: (954) 724-3900

Early Care and Education Programs For Pre-Kindergarten Children With Special Needs

Children's Resource Child Dev. Center
8571 S.W. 112 Street
(305) 596-6966
(First Steps Preschool for Children with/without Disabilities)

Disabilities Resources, Inc.
(631) 585-0290
http://www.disabilityresources.org

Early Head Start (Miami - Dade CAA)
(305) 694-8477
(6 locations; Birth to 36 months/low-income families)

Easter Seals Miami-Dade
1475 N.W. 14 Avenue
Miami, FL. 33125
(305) 325-0470
(Birth-14 ADHD/LD - Inclusion Model)

Head Start Program (Miami-Dade CAA)
395 N.W. 1st Street - Room 103
Miami, FL. 33128
(305) 347-4622
(87 locations; Children ages 3-4 of low-income families.)

Learning Experience School
536 Coral Way
Coral Gables, FL. 33134
(305) 445-0475
(Developmentally Delayed Children; Birth - Age 23.)

Marian Center Inclusion Model
15701 N.W. 37 Avenue
Opa Locka, FL. 33054
(305) 625-8354
(Ages 2 - 4)

Preschool Inclusion Early Care and Education Programs

(The following centers have administration committed to the concept of inclusion. Gold Seal Centers are accredited centers that have been recognized by the State of Florida as quality programs).

Bet Shira Early Childhood Center
7500 S.W. 120th Street
(305) 238-2606

Bethany Child Development Center (Gold Seal)
911 N.W. 183rd Street
(305) 652-5995

Camelot Preschool
9771 E Indigo Street
(305) 235-2993

Cecile's Day Care
183 N.E. 57th Street
(305) 751-7437
Location #2
Cecile's Day Care
69 NW 3rd Avenue
(305) 759-4209

Centro Hispano
141 N.W. 27th Avenue
(305) 576-6446

Centro Hispano Child Care Center
144 N.W. 26th Street
(305) 576-1923

Centro Mater West (Gold Seal)
8420 N.W. 103rd Street
(305) 827-1050

Carole Glassman Child Care- (YWCA) (Gold Seal)
112 N.W. 3rd Street
(305) 375-3222

Cherish Day Care Center
4201 N.W. 2md avenue
(305) 576-1888

***Children's Center at Baptist Hosp.**
8900 N. Kendall Drive
(305) 596-6523

Children's Hour Child Care
11101 S.W. 184th Street
(305) 238-4135

Discovery Times Inc. D/B/A/ Discovery Years (Gold Seal)
5152 West Flagler
(305) 266-9263

Eighth Street School
1405 N.E. 8th Street
(305) 247-0183

Elizabeth Curtis Child Care Center
4300 N.W. 12th Avenue
(305) 633-8130

Fulford Preschool
1900 N.E. 164th Street
(305) 947-9266

Gerry Sweet Child Care Center- (YWCA) (Gold Seal)
351 N.W. 5th Street
(305) 377-9922

Good Shepherd Child Care Center
18601 S.W. 97th Avenue
(305) 235-1756

Homestead Family YMCA
1034 N.E. 8th Street
(305) 247-0393

Hudson ECE Center (Gold Seal)
1427 N.W. 2nd Avenue
(305) 247-8818

KIDCO Child Care, Inc.
3630 N.E. 1st Court
(305) 573-1515

Kids-R-Ific
12807 S.W. 280 Street
(305) 257-4301

Knowledge Beginings / FPL (Gold Seal)
10190 S.W. 344 Street
(305) 246-7342

Le Jardin IV
320 N.W. 2nd Street
(305) 246-3050

Le Jardin V
616 West Palm Drive
(305) 248-0047

***Little Cruisers Child Dev. Center (Gold Seal)**
1080 Port Boulevard
(305) 539-4080

My Kid's Place
7722 N.E. 3rd Court
(305) 756-1003

Our Little Ones
55-69 N.W. 59th Street
(305) 758-0046

Paradise Christian School (Gold Seal)
6184 W. 21st Court
(305) 828-7477

Plymouth Preschool (Gold Seal)
3010 Desoto Blvd.
(305) 448-8744

Rainbow Intergenerational Child Care Center
700 S.W. 8th Street
(305) 858-0887
833 6th Street, MB
(305) 532-4377

RCMA-Andrew Child Dev. (Gold Seal)
19200 S.W. 380 Street
(305) 242-2597

RCMA-Centro Villas Child Dev. (Gold Seal)
35501 S.W. 187 Avenue
(305) 242-2588

RCMA-Everglades I and II Child Dev. (Gold Seal)
13500 S.W. 187 Avenue
(305) 242-2595

RCMA-Florida City Area (Gold Seal)
19200 S.W. 380 St.(Trailer C)
(305) 242-5946

RCMA-Redlands Child Dev. (Gold Seal)
16085 S.W. 293 Drive
(305) 242-2584

RCMA-So. Dade Infants & Preschool Child Dev. (Gold Seal)
13600 S.W. 312 St.
(305) 242-2575

Redlands Christian
Migrant Association PreK (Gold Seal)
16088 S. W. 293 Drive
Homestead, FL 33033
(305) 242-2584

REM Learning Center (2 Sites) (Gold Seal)
16400 S.W. 147th Avenue
14465 S.W. 144th Street
(305) 235-0300

Sagrada Familia Child Care Center
970 S.W. 1st Street
(305) 324-5424

South Miami Lutheran Preschool (Gold Seal)
7190 Sunset Drive
(305) 661-3299

Spark's Day Care and Kindergarten
8129 N.W. 12th Court
(305) 696-9590

St. Albans Child Care Center
3464 Brooker Street
(305) 443-1234

***The Village-Fresh Start Child Care**
3180 Biscayne Blvd.
(305) 571-1403

***UM Canterbury Preschool (Gold Seal)**
1150 Stanford Drive
(305) 284-5437

U.M. Canterbury (Medical)
1400 N.W. 10th Avenue
(305) 284-5437

Unific Academy of Learning
1600 N.W. 95th Street
(305) 691-4600

YMCA - Carver
401 N.W. 71 Street
(305) 759-3317

YMCA - MLK
2000 N.W. 62nd Street
(305) 643-0500

(Information on these 3 pages was provided by: Miami-Dade County Public Schools, Office of Programs for Prekindergarten Children with Disabilities)

* Special requirements needed for enrollment. Please call to inquire.

SERVICE & RESOURCE AGENCIES ACCORDING TO EXCEPTIONALITIES

Autism

Autistic Child Advocates Association
19732 N.E. 12 Place
Miami, FL 33179
(305) 758-5912

Autism Society of America
So. Florida Chapter
Saturday Recreation/Respite Programs
(305) 9371416 Evenings

Center for Autism &
Related Disorders (C.A.R.D.)
(Including Asperger's Syndrome)
University of Miami
1204 Dickinson Drive - Room 37C
P.O. Box 248768
Coral Gables, FL 33124
(305) 284-6563
(800) 9-AUTISM

Children & Families, Dev. Services
Residential/Respite Information
401 N.W. 2nd Avenue - Suite 510
Miami, FL 33128
(305) 377-5049

Children's Psychiatric Center, Inc.
15155 N.W. 7 Avenue
Miami, FL 33169
(305) 558-2480 (Hialeah)
(305) 685-0381 (North Dade)
(305) 274-3172 (South Dade)

Deering Hospital/Grant Center
20601 S.W. 157 Avenue
Miami, FL 33187
(305) 251-2500
www.deeringhospital.com

Learning Experience School
536 Coral Way
Coral Gables, Fl 33134
(305) 445-0475

Mailman Center for Child Development
1601 N.W. 12 Avenue
Miami, FL 33136
(305) 243-6631

Mental Health Association
of Dade County, Inc.
227 N.E. 17 Street
Miami, FL 33132
(305) 379-3642

Miami Children's Hospital/
Division of Psychiatry
(305) 666-6511, Ext. 2465

National Society for Autistic Children
234 Massachusetts Avenue, N.W.-Suite 1017
Washington, D.C. 20005

South Florida A.S.A. Chapter
1871 N.E. 210 Street
North Miami Beach, FL 33179
(305) 931-1227

SERVICE & RESOURCE AGENCIES ACCORDING TO EXCEPTIONALITIES

Developmentally/Mentally Delayed

Association for Retarded Citizens (A.R.C.)
5555 Biscayne Blvd.
Miami, FL 33137
(305) 759-8500

Andrea Draizar, Ph.D. & Assoc., P.A.
1061 N Kendall Dr, Suite #113
Miami, Fl 33176
(305) 595-4271
(305) 595-4227 Fax

Department of Children & Families
Office of Developmental Services
401 N. W. 2 Avenue
Miami, FL 33128
(305) 377-5049 (Main Office)

Community Committee for Developmental Handicaps (C.C.D.H.)
8585 Sunset Dr. #75
Miami, FL 33143
(305) 596-1160
ccdh@ccdh.org

Member Agencies of CCDH

- Advocates for Opportunities, Inc.
- American Habilitation Services, Inc.
- Association for Jewish Special Education
- Association for Retarded Citizens, South Florida
- Association for the Development of the Exceptional
- Autism Society of America S. Florida Chapter, Inc.
- Avanti Support, Inc.
- Behavior Analysis and Therapy, Inc.
- Casterline Group Home, Inc.
- Children's Home Society of Florida/S.E. Div.
- Children's Resources
- Choices in Support and Services, Inc.
- City of Miami Beach's Log Cabin Training Center
- City of Miami Programs for Persons with Disabilities
- Community Habilitation Center, Inc.
- Consumer Opportunities, Inc.
- Easter Seals Miami-Dade, Inc.
- Goodwill Industries of South Florida, Inc.

Member Agencies of CCDH (Continued)

- Hope Center, Inc.
- Jewish Vocational Service, Inc.
- Learning Experience School
- Life Plus Support Coordination Services
- MACtown, Inc.
- Mains'l Florida, Inc.
- MARC Monroe Association for Retarded Citizens
- Miami Dade County Parks – Leisure Access Services
- Marian Center Services
- National Mentor Health Care, Inc.
- North Dade Center, Inc.
- Parent to Parent of Miami, Inc.
- Partners For Personal Choice
- People First of South Florida
- Sunrise Community & Opportunities
- Support Coordination Services
- United Cerebral Palsy Assoc. of Miami, Inc.
- University of Miami/Mailman Center & /Debbie Institute
- Williams Group Home
- Worrell/Mitchell Group Home

Easter Seals Society of Miami-Dade Co.
1475 N.W. 14 Avenue
Miami, FL 33125
(305) 325-0470
essdade@aol.com

Family Resource Center of Miami-Dade County
9500 S.W. Dadeland Blvd. - Suite 350
Miami, FL 33156
(305) 576-6190

Head Start Program (Miami-Dade CAA)
395 N.W. 1 Street - Room 103
Miami, FL 33128
(305) 347-4622
(37 locations, serving children ages 3 and 4 of low-income families)

Hope Center
666 S.W. 4 Street
Miami, FL 33130
(305) 545-7572

Learning Experience School
536 Coral Way
Coral Gables, FL 33134
(305) 445-0475
(Developmentally delayed children and young adults/Birth-23yrs)

Linda Ray Center
750 N.W. 15 Street
Miami, FL 33136
(305) 325-1818

Mailman Center for Child Development
Debbie School/Early Intervention Program
1601 N.W. 12 Avenue
Miami, FL 33136
(305) 243-5600
(Developmentally delayed children/3-36 months)

March of Dimes Resource Center
(1-888) MODIMES

March of Dimes Birth Defects Foundation
1275 Mamaroneck Ave.
White Plains, New York 10605

Marian Center
15701 N.W. 37 Avenue
Opa Locka, FL 33054
(305) 625-8354

The Possible Dream Foundation
(Down Syndrome)
13830 SW 102 Ave
Miami, FL 33176
(305) 386-9115

Sunrise Community, Inc./
Julia E. Niarchos/S.Florida Programs
9040 Sunset Drive - Suite 55
Miami, FL 33173
(305) 245-6150

United Cerebral Palsy of Miami, Inc.
1411 N. W. 14 Avenue
Miami, FL 33125
(305) 325-1080
www.ucpsouthflorida.org

SERVICE & RESOURCE AGENCIES ACCORDING TO EXCEPTIONALITIES

Emotionally Disabled

Alcohol & Drug Abuse:

Columbia Behavioral Hospital
11100 N.W. 27 Street
(305) 591-3230
(Alcohol, Drugs & Emotional Problems)

Department of Children & Families
401 N.W. 2 Avenue - Suite N-812
Miami, FL 33128
(305) 377-5029
(Alcohol, Drug Abuse & Mental Health)

Here's Help - North/South Area
9016 S.W. 152 Street
Miami, FL 33157
(305) 238-8500
(Alcohol & Drug Abuse/Inpatient-Outpatient Treatment)

Eating Disorders:

Anorexia-Bulimia Resource Center
111 Majorca Avenue
Coral Gables, FL 33134
(305) 448-8325

Eating Disorders
Rader Institute
(800) 255-1818

General Programs:

Behavioral Health Specialty Care Network
(Florida KidCare)
(KidCare Office 1-888-540-5437)

Catholic Family & Children's Services
(305) 758-0024

Community Outreach Program
11025 SW 84 Street
Miami, FL 33125
(305) 273-4180

Family Counseling Services
10651 N. Kendall Drive
Miami, FL 33176
(305) 271-9800

Jewish Family & Children's Services
(Main Office)
1790 S.W. 27 Avenue
Miami, FL 33145
(305) 445-0555
www.jfsmiami.org

Miami-Dade County Youth & Family Development
11025 S.W. 84 Street
Miami, FL 33173
(305) 270-2932

Switchboard of Miami
(305) 358-4357
(Referral Information)

Youth Co-Op., Inc.
3525 NW 7 St
Miami, FL 33125
(305) 643-6730

Psychiatric and Psychological Services:

Atlantic Shores Healthcare
(Children's Division)
10000 S.W. 84 Avenue
Pembroke Pines, FL 33023
(954) 392-3000

CHARLEE of Dade County, Inc.
5915 Ponce De Leon Blvd. Suite #26
Coral Gables, Fl. 33146
(305) 665-7365

Childhood Anxiety & Phobia Program (CAPP-FIU)
University Park - DM 201
Miami, FL 33199
(305) 348-1937

Children's Psychiatric Center, Inc.
(North)
15490 N.W. 7 Avenue #101
Miami, FL 33169
(305) 685-0381
(South)
9380 Sunset Drive, Suite B-120
Miami, FL 33173
(305) 274-3172
(also Parent Effectiveness Training)
(Hialeah)
430 W. 66 Street, Arcade #4-5
Hialeah, FL 33012
(305) 558-2480

Community Mental Health Center Northwest Dade
4175 W. 20 Avenue
Hialeah, FL 33012
(305) 828-4777

Community Mental Health Center
South Dade (CHI)
10300 S.W. 216 Street
Miami, FL 33190
(305) 253-5100

Deering Hospital/Grant Center
20601 S.W. 157 Avenue
Miami, FL 33187
(305) 251-2500
(Inpatient Psychiatric Hospital)

Douglas Gardens Comm. Mental Health
(Miami Beach)
701 Lincoln Road
Miami Beach, FL 33139
(305) 531-5341

Highland Park Hospital
1660 N.W. 7 Court
Miami, FL 33136
(305) 324-8111

Homestead Behaviorial Clinic
447 N.E. 8 Street
Homestead, FL 33030
(305) 248-3488

Jackson Memorial Hospital
(Child & Adolescent Psychiatric Center)
1611 N.W. 12 Avenue
Miami, FL 33136
(305) 585-6433

Locktown Community Mental Health
15055 NW 27th Avenue
Miami, FL
(305) 628-8984

Mental Health Assoc./Miami-Dade Co.
227 N.E. 17 Street
Miami, FL 33132
(305) 379-2673

Miami Behavioral Health Center
3850 W. Flagler St.
Miami, FL 33134
(305) 774-3300

Miami Children's Hospital
6125 S.W. 31 Street
Miami, FL 33155
(305) 666-6511
(Emotional Problems/InPatient/11-18 yrs)

Miami-Dade Co. Psychological Assoc.
5783 S.W. 60 Street
Miami, FL 33143
(305) 667-2078

Multi-Agency Network/For Students With Emotional Disturbance(SEDNET)
5555 S.W. 93 Avenue-Annex Trailer #3
Miami, FL 33165
(305) 598-2436

Oak Plaza Mental Health Group
8525 S.W. 92 Street, Suite B-8
Miami, FL 33156
(305) 598-5558

PsychSolutions, Inc.
1320 S. Dixie Hwy., Suite 1140
Coral Gables, FL 33146
(305) 668-9000

SERVICE & RESOURCE AGENCIES ACCORDING TO EXCEPTIONALITIES

Deaf or Hard of Hearing

Alexander Graham Bell Association for the Deaf
3417 Volta Place N.W.
Washington, D.C. 20007
(202) 337-5220

Department of Children & Families
Office of Vocational Rehabilitation
District XI
(305) 375-5750

Deaf Services Bureau
1320 S. Dixie Highway - Suite 760
Miami, FL 33143
(305) 668-4407
(305) 668-3323 (TTY)

Florida Power and Light Co.
(Aid for Hearing/Speech Impaired)
(800) 432-6554 (TTY)

Florida School for the Deaf & Blind
(Residential & day classes for children & families)
207 N. San Marco Avenue
St. Augustine, FL 32084
(904) 827-2200

Gallaudet University-College Program For the Hearing Impaired
800 Florida Avenue, N.E.
Washington, D.C. 20002-3695
(202) 651-5000

Gallaudet University Press
(Publisher of books on hearing loss)
800 Florida Avenue, N.E.
Washington, D.C. 20002-3695
(800) 621-2736
(800) 621-8476 (FAX)
(888) 630-9347 (TTY)

Hearing/Speech Center of Florida, Inc.
9425 SW 72 Street
Suite #261
Miami, FL
(305) 271-7343; Fax (305) 271-7949

International Association of Parents Of the Deaf
814 Thayer Avenue
Silver Spring, MD 20910

Jackson Memorial Hospital/
Division of Audiology
1666 N.W. 10 Avenue - ACC East Bldg.
Miami, FL 33136
(305) 585-6451

John Tracy Clinic
(Free correspondence course for parents of preschool hearing impaired children)
806 West Adams Blvd.
Los Angeles, CA 90007

Mailman Center for Child Development
Depts. of Audiology, Speech/Language & Tactual Speech Project
1601 N.W. 12 Avenue
Miami, FL 33136
(305) 243-6961

Miami-Dade County Public Schools
Florida Diagnostic & Learning Resources System/South
(FDLRS/South)
Audiology Services
5555 S.W. 93 Avenue
Miami, FL 33165
(305) 274-3501

Miami Hearing and Speech Center
3661 South Miami Avenue - Suite 410
Miami, FL 33133
(305) 854-8171

National Association for Hearing
and Speech Action (NASHA)
10801 Rockville Pike
Rockville, MD 20852

Oberkotter Foundation
(For information on public and private schools and
centers where deaf children are learning to listen
and to speak.)
PO Box 50215
Palo Alto, Ca 94303-9465
For free copies of Videos on Oral Education Call:
(877) 672-5332
(877) 672-5889 TTY
www.oraldeaf.org

Schott Memorial Center
for the Deaf and Handicapped
6591 S.W. 124 Avenue
Ft. Lauderdale, FL 33030
(954) 434-3306

Self Help for Hard of Hearing People,
Inc. (SHHH)
7800 Wisconsin Avenue
Bethesda, MD 20814

South Florida Registry of
Interpreters for the Deaf
Miami Springs Lions Club
301 Swallow Drive
Miami Springs, FL 33122
(305) 444-2266 (FAX)

South Miami Hospital/
Child Development Center
(Audiology-Speech/Language Pathology)
6200 S.W. 73 Street
Miami, FL 33143
(305) 663-5080

Speech Pathology Educational Center (SPEC)
9211 SW 40 Street
Miami, Fl 33165
(305) 220-7778

SERVICE & RESOURCE AGENCIES ACCORDING TO EXCEPTIONALITIES

Physically Disabled, Chronically Ill, Brain Injured and Health Impaired

American Heart Association
of Greater Miami, Inc.
2600 SW 3rd Avenue - Suite 900
Miami, FL 33129
(305) 856-1449
www.americanheart.org

Andrea Draizar, Ph.D. & Assoc., P.A.
1061 N Kendall Dr, Suite #113
Miami, Fl 33176
(305) 595-4271
(305) 595-4227 Fax

Arthritis Foundation
(Miami-Dade)
4649 Ponce de Leon Blvd.
Coral Gables, FL 33146
(305) 669-6870
www.arthritis.orginfo.fl.b8@arthritis.org

Aventura Hospital
20900 Biscayne Blvd.
Aventura, FL 33180
(305) 682-7000
www.adventurahospital.com

Brain Injury Association of Florida
North Broward Medical Center
201 East Sample Road
Pompano Beach, FL 33064
(954) 786-2400
(800) 992-3442

Brain Injury Association of Florida
Miami Family Support Center
Dade/Monroe County
8585 Sunset Drive, East Atrium, Suite 30
Miami, FL 33143
(1-800) 992-3442

Center for Pediatric Therapy
2801 Ponce de Leon Blvd. - Suite 250
Coral Gables, FL 33134
(305) 448-7101
www.childrenstherapy.com
cptgables@aol.com

Children's Cancer Caring Center
Cleveland Clinic Hospital
2833 N. Ocean Blvd.
Ft. Lauderdale, FL
(954) 568-7416

Children's Rehab Network
8585 Sunset Dr.
Miami,Fl.33143
(305)270-9026 or
14 NE 6 St.
Homestead,Fl. 33030
(305)245-9900
crnppec@bellsouth.net

Children & Families/Department of
Children's Medical Services (CMS)
(North Office)
Jackson Memorial Hospital
1500 N.W. 12 Avenue - Room 829
Miami, FL 33136
(305) 325-2830
(South Office)
Miami Children's Hospital
3100 SW 62 St
Miami, FL 33155
(305) 666-6511
www.mch.com

Client Relations Office/
Medically Needy
(Dade & Monroe - English & Spanish Information, applications for Food Stamps, Medicaid, etc.)
1320 Dixie Highway
Miami, FL 33146
(305) 377-5068

Cystic Fibrosis Fitness Program & Diabetes Support Group
Doctor's Hospital of Coral Gables
5000 University Drive
Coral Gables, FL 33134
(305) 666-2111

Diabetes Education
South Miami Hospital - Homestead
160 N.W. 13 Street
Homestead, FL 33030
(305) 248-3232, Ext. 3530
www.baptisthealth.net

Disabled Parking Program
(Parking permits are available from any tax collector or tag agent's office)
(305) 375-5678

Dolphins Plus
PO Box 2728
Key Largo, FL 33037
(305) 451-1993
(305) 451-3710
www.dolphinplus.com

Easter Seals Miami-Dade, Inc.
1475 N.W. 14 Avenue
Miami, FL 33125
(305) 325-0470
essdade@aol.com

Brain Injury Association of Florida
North Broward Medical Center
201 East Sample Road
Pompano Beach, FL 33064
(954) 786-2400
(800) 992-3442
www.biaf.org
info@biaf.org

Florida's Central Directory
(for information regarding all disabilities)
(305) 596-1160 (Miami-Dade Co.)
(800) 654-4440 (all other counties)

Florida Elks Children's Therapy Services
(305) 278-2044

Head and Spinal Cord Injury
401 N.W. 2 Avenue - Suite 221
Miami, Fl 33128
(305) 377-5464
(800) 342-0778

Island Dolphin Care
31 Corrine Pl.
Key Largo, FL 33037
(305) 451-5884; (305) 453-5399 Fax
www.islanddolphincare.orgfonzie@islanddolphincare.org

Jackson Memorial Hospital
1611 N.W. 12 Avenue
Miami, FL 33136
(305) 325-7429

Jewish Vocational Services
735 N.E. 125 Street
Miami, FL 33161
(305) 899-1587

Kiwanis Horses & Handicapped
(305) 271-2210
(305) 274-6423

Learning Experience School
536 Coral Way
Coral Gables, FL 33134
(305) 445-0475

Mailman Center/Child Development
1601 N.W. 12 Avenue
Miami, FL 33136
(305) 243-5600

March of Dimes Resource Center
(1-888) MODIMES

March of Dimes Birth Defects Foundation
1275 Mamaroneck Ave.
White Plains, New York 10605

Medicaid Information
(305) 377-5148

Medicaid Transportation
(Call 2 full working days prior to appointment)
(305) 263-7301

Mentor
(complex medical needs)
11900 Biscayne Blvd.
Suite 509
Miami, FL 33181
(305) 895-1740

Miami Children's Hospital
Physical & Occupational Therapy Department
3100 S.W. 62 Street
Miami, FL 33155
(305) 666-6511

Muscular Dystrophy Association
6363 - 10 Street - Room 311
Hollywood, FL 33024
(954) 970-9696

Physical Handicaps
(Service and Referrals)
Florida's Central Directory (Miami Dade site)
(305) 596-1160

Sickle Cell Anemia (Service & Referrals)
Children's Medical Services
(305) 325-2830
Miami Children's Hospital
(305) 669-6931
Mt. Sinai Medical Center
(305) 674-2121

South Miami Hospital/
Child Development Center
(Occupational/Physically Therapy Dept.)
6200 S.W. 73 Street
Miami, FL 33143
(305) 663-5080
www.baptisthealth.net

Special Disabilities & Healthcare Needs
(800) 654-4440
locally call (305) 596-1160
www.centraldirectory.org

Spina Bifida Association of S.E. Florida
(305) 220-2559

United Cerebral Palsy Assoc. of Miami
1411 N.W. 14 Avenue
Miami, FL 33125
(305) 325-1080
www.ucpsouthflorida.org

SERVICE & RESOURCE AGENCIES ACCORDING TO EXCEPTIONALITIES

Specific Learning Disabled

Atlantis Academy
9600 S.W. 107 Avenue
Miami, FL 33176
(305) 271-9771

Broader Opportunities for
the Learning Disabled
(B.O.L.D.)
P.O. Box 546407
Surfside, FL 33154
(305) 866-3262

Easter Seals Miami-Dade, Inc.
1475 NW 14 Avenue
Miami, Florida 33125
(305) 325-0470
essdade@aol.com

Family and Children's Achievement Center
11025 S.W. 84 Street
Miami, FL 33173
(305) 270-2932

House of Learning, Inc.
10545 S.W. 97 Avenue
Miami, FL 33176
(305) 274-9259

McGlannan School
10770 S.W. 84 Street
Miami, FL 33173
(305) 274-2208

Vanguard School
3939 Main Highway
Coconut Grove,Fl. 33133
(305) 445-7992

SERVICE & RESOURCE AGENCIES ACCORDING TO EXCEPTIONALITIES

Speech & Language Impaired

Ambilingual Associates
900 W. 49 Street - Suite 330
Hialeah, FL 33012
(305) 556-0121

Andrea Draizar, Ph.D. & Assoc., P.A.
1061 N Kendall Dr. Suite #113
Miami, Fl 33176
(305) 595-4271
(305) 595-4227 (Fax)

Betancourt Stuttering Center
6035 SW 40th Street
Miami, Fl 33155
(305) 668-4399

Center for Bilingual Speech & Disorders
8600 SW 92nd Street - Suite 204
Miami, FL 33156
(305) 279-2428
www.cbsld.com

Center for Pediatric Therapy
2801 Ponce de Leon Blvd.
Coral Gables, FL 33134
(305) 448-7101
(Occupational, Physical & Speech Therapy)

Children's Rehab Network
8585 Sunset Drive
Miami,Fl.33143
(305)270-9026 or
14 NE 6 St.
Homestead,Fl. 33030
(305) 245-9900

**Easter Seals Society
of Miami-Dade County**
1475 N.W. 14 Avenue
Miami, FL 33125
(305) 325-0470
(Occupational, Physical & Speech Therapy)
essdade@aol.com

**Hearing & Speech Center
of Florida, Inc.**
9425 SW 72ND Street – Suite #261
Miami, FL 33173
(305) 271-7343
(305) 271-7949 (Fax)

Kendall Speech & Language Center
10725 S.W. 104 Street
Miami, FL 33176
(305) 274-7883

Mailman Center/Child Development
1601 N.W. 12 Avenue
Miami, FL 33136
(305) 243-5600

Miami Children's Hospital
(Speech and Language Department)
6125 S.W. 31 Street
Miami, FL 33155
(305) 666-6511
(Occupational and Physical Therapy also provided)
www.mch.com

**Miami Center for Speech Language Pathology
Bilingual Pediatric Specialists**
6035 Bird Road – Suite #203
Miami, Fl 33155
(305) 667-2325
(305) 667-5571 (Fax)

Speech Pathology Educational Center (SPEC)
9211 SW 40 Street
Miami, Fl 33165
(305) 220-7778

**South Miami Hospital/
Child Development Center**
(Audiology/Speech Pathology Dept.)
6200 S.W. 73 Street
Miami, FL 33143
(305) 663-5080
www.baptisthealth.net

South Miami Speech Clinic
(United Testing Service)
9485 Sunset Drive - Suite A200
Miami, FL 33173
(305) 595-5554

United Cerebral Palsy Association of Miami
1411 NW 14 Avenue
Miami, FL 33125
(305) 325-1080
www.ucpsouthflorida.org

SERVICE & RESOURCE AGENCIES ACCORDING TO EXCEPTIONALITIES

Varying Exceptionalities

Association for Retarded Citizens (A.R.C.)
Project THRIVE
(Infant Preschool Stimulation Program)
5555 Biscayne Blvd.
Miami, FL 33137
(305) 759-8500

Andrea Draizar, Ph.D. & Assoc., P.A.
1061 N Kendall Dr, Suite #113
Miami, Fl 33176
(305) 595-4271
(305) 595-4227 Fax

Community Blood Centers of Florida
Formerly, American Red Cross
354 N.W. 1 Avenue
Homestead, FL 33030
(305) 326-8888
(Rental of infant and toddler car seats, minimal fee)

Brain Injury Association of Florida
North Broward Medical Center
201 East Sample Road
Pompano Beach, FL 33064
1 (800) 992-3442

Brain Injury Association of Florida
Miami Family Support Center
Dade/Monroe County
8585 Sunset Drive, East Atrium, Suite 30
Miami, FL 33143
(1-800) 992-3442

Community Committee for Developmental Handicaps (C.C.D.H.)
7925 N.W. 12 Street - Suite 325
Miami, FL 33126
(305) 594-4466

Dept. of Children & Families (Early Intervention Coordination)
1400 N.W. 10 Avenue
Miami, FL 33125
(800) 247-5437

Easter Seals Society of Miami-Dade County
1475 N.W. 14 Avenue
Miami, FL 33125
(305) 325-0470
essdade@aol.com

Head Start Program
395 N.W. 1 Street
Miami, FL 33128
(305) 347-4622
(ages 3-5 years)

Learning Experience School
536 Coral Way
Coral Gables, FL 33134
(305) 445-0475

Mailman Center for Child Development/Debbie School
1601 N.W. 12 Avenue
Miami, FL 33136
(305) 243-6961
(Services for developmentally delayed children, ages 3-36 months)

Redlands Christian Migrant Assoc./Special Effort
16088 S. W. 293 Drive
Homestead, FL 33033
(305) 242-2581

South Miami Hospital/ Child Development Center
6200 S.W. 73 Street
Miami, FL 33143
(305) 663-5080
www.baptisthealth.net

United Cerebral Palsy Association of Miami, Inc.
1411 N. W. 14 Avenue
Miami, FL 33125
(305) 325-1080
www.ucpsouthflorida.org

SERVICE & RESOURCE AGENCIES ACCORDING TO EXCEPTIONALITIES

Visually Impaired

Bascom Palmer Eye Institute
900 N.W. 17 Street
Miami, FL 33136
(305) 326-6000

Blind Children's Center
(Complimentary materials available
to parents of visually impaired children)
4120 Marathon Street
P.O. Box 29159
Los Angeles, CA 90029-0159
(1-323) 664-2153
(1-800) 222-3566

Children's Medical Services
(South Office)
Miami Children's Hospital
6221 S.W. 31 Street
Miami, FL 33155
(305) 669-6931

(North Office)
1500 N.W. 12th Avenue
Suite 829, Miami, FL 33136
(305) 325-2830

Division of Blind Services
401 N.W. 2 Avenue
Miami, FL 33128
(305) 377-5339
www.fcn.state.fl.us/dbs

Division of Blind Services
Tallahassee, FL
(800) 342-1828

Division of Vocational Rehabilitation
(305) 571-5666

Florida School for the Deaf & Blind
(Resources, Residential & Day Classes for children and families)
207 N. San Marco Avenue
St. Augustine, FL 32084
(904) 827-2200

Goodwill Industries
2121 N.W. 21 Street
Miami, FL 33142
(305) 325-1394

Miami Dade Community College
(Low cost optometric services,
letter request only)
950 N.W. 20 Street
Miami, FL 33127
(305) 237-4000

Miami-Dade County Public Schools
Exceptional Student Education Office
1500 Biscayne Blvd. - Room 409
Miami, FL 33181
(305) 995-1721
www.mdcc.edu

Miami Lighthouse for the Blind
601 S.W. 8 Avenue
Miami, FL 33130
(305) 856-2288

Miami Lions Club Central Office
601 S.W. 8 Avenue
Miami, FL 33130
(305) 858-1019

Parents of the Visually Impaired
(305) 388-7497

Prevent Blindness Florida
(for vision screening, evaluation, and follow-up
especially for families without insurance)
10300 Sunset Drive - Room 205
Miami, FL 33173
(1-800) 817-3595
Office Hours: 10:00 A.M. - 2:00 P.M.

Recording for the Blind and Dyslexic
Florida Unit
6704 S.W. 80 Street
Miami, FL 33143
(305) 666-0552

Talking Book Library Services
150 N.E. 79 Street
Miami, FL 33138
(305) 751-8687
(305) 751-8688
www.talkingbooks.com

VISION
(A parent support group, provides opportunities for parents of children with visual impairments)
(407) 898-2483
comcite@aol.com

ABUSE

Alcohol & Teen Resources

Family Counseling:

Counseling Ministry of S. Florida
(305) 445-4672 (English)
(305) 441-1836
counsmin@aol.com

Miami-Dade County Public Schools/
Trust Counselors
(Available in most middle schools & high schools; call your local school for more info.)

Family Counseling Services
of Greater Miami
(305) 271-9800 (Central Branch)
(305) 271-9800 (West Branch)
(305) 232-1610 (South Branch)

Family Services
(Crisis Intervention)
1-(305) 359-1640

Jewish Family Services
(305) 445-0555
www.jfsmiami.org

Hospital-Based Adolescent Programs:

Children's Psychiatric Center
(305) 685-0381
(305) 685-8244

Deering Hospital/Grant Center
(305) 251-2500
www.deeringhospital.com

Miami Children's Hospital
(305) 663-8439
www.mch.com

Windmoor Healthcare of Miami
(305) 642-3555

Substance Abuse Treatment:

Health and Recovery Center
(Maternal)
(305) 585-5188

Here's Help
(Residential & Outpatient)
(305) 685-8201

Village
(Residential dual diagnosis)
(305) 573-3784
www.the-village.org

Support Groups:

Alcoholics Anonymous
(305) 371-7784

Al-Anon Family Groups
(305) 663-1432

Families Anonymous
(305) 443-0303

Narcotics Anonymous
(305) 620-3875 (North)
(305) 265-9555 (South)

ABUSE

Domestic Violence Resources

Child Is The Victim:

CHARLEE of Dade County, Inc.
5915 Ponce De Leon Blvd. Suite 26
Coral Gables, Fl. 33146
(305) 665-7365

Children & Families/Department of
(800) 96-ABUSE

Heroes (University of Miami/ Mailman Center for Child Dev.)
(305) 243-6864

Parent Is The Abuser:

Crisis Nursery
(305) 385-8238 (Emergency Child Care)

Parent Suspects Abuse:

Children & Families/Department of
(800) 96-ABUSE

Children's Psychiatric Center
(305) 558-2480 (Hialeah)
(305) 685-0381 (North)
(305) 274-3738 (South)

Jackson Memorial Hospital (JMH) Rape Treatment Center
(305) 585-7273 (Hot Line)
(305) 585-5185 (Office)

Victims of Family Abuse:

Advocates for Victims
(North)
7831 N.E. Miami Court
Miami, FL 33138
(305) 758-2546

(South)
51 West Mowry Drive
Homestead, FL 33030
(305) 247-4249

Domestic Violence Hotline
(305) 547-3170 (24 hours a day)
www.judl1.flcourts.org

Inn Transition Program
P.O. Box 610815
North Miami, Fl 33181
(305) 899-4600

Miami-Dade Co. Abuse Victim Services
(Counseling for victim & abuser)
(305) 271-9800
e-mail:fcounsel@familycounseling.org

Mother Teresa's Women In Distress Shelter
(305) 326-0032

Salvation Army/ Women In Distress Shelter
1907 NW 38TH Street
Miami, Florida
(305) 637-6720

Victims of Past Abuse:

Adult Children Of Alcoholics
(305) 663-1432 (Through AL-ANON)

Adult Children Of Dysfunctional Families (Switchboard of Miami)
(305) 358-HELP
(305) 358-1640
www.switchboardmiami.org

Overeaters Anonymous
(305) 274-8800

(800) 4-A-CHILD
24 hour hotline (Counseling & Referral)

ABUSE

Finding Shelter From Abuse

Emergency and transitional shelters for families, women and children. These programs accept donations of cash and goods.

CHARLEE Of Dade County, Inc.
5915 Ponce De Leon Blvd. Suite #26
Coral Gables, Fl. 33146
(305) 665-7365

Homestead Shelter
326 NW 3 Ave.
Homestead, Fl. 33030
(305) 246-8956

Miami Bridge Shelter
2810 N.W. South River Drive
Miami, FL 33125
(305) 635-8953
(Intake: 24 hours. For youths ages 10 to 17.)

Miami Women and Children's Shelter
2250 N.W. First Avenue
Miami, FL 33127
(305) 571-2250
(Intake: 4:00 to 5:00 P.M. Women without children. Women with children call first. No boys over 8.)
www.caringplace.org

Mother Theresa's Sisters of Charity
724 N.W. 17 Street
Miami, FL 33136
(305) 545-4699 or 326-0032
(Intake: 4:00 to 5:00 P.M. Women and children. No boys over 6.)

New Life Family
3620 N.W. First Avenue
Miami, FL 33142
(305) 576-5521 or 573-3333
(Intake: 24 hours. Priority given to couples with sons 12 or older. Males with children need legal documents.)

Safespace
North: (305) 758-2546
South: (305) 247-4249
(For battered women only.)

Salvation Army
1398 S.W. First Street
Miami, FL 33135
(305) 637-6720
(Intake: 24 hours. Women and children. No boys over 12.)

ABUSE

Hotline Numbers

Abuse Registry
1-800-96-ABUSE
1-800-962-2873

Family Violence Shelters
305-758-2546

Missing Children Information Clearinghouse
1-888-FL-MISSING
1-888-356-4774

National Runaway Switchboard
1-800-621-4000

Parent Hotline
1-888-4-1-FAMILY
1-888-413-2645

Runaway Hotline (Florida)
1-800-RUNAWAY
1-800-786-2929

Switchboard of Miami
1-800-358-HELP
1-800-358-1640

ABUSE

Sexual Abuse Resource Directory

Abuse Report/Hotline	(800) 96-ABUSE
American Bar Association	(312) 988-6217
Child Assault Prevention Program (CAPP)	(305) 377-2277
Child Protection Team (CPT) University of Miami	(305) 243-7550
Children & Families/Department of (Information and Referral)	(305) 377-5055
Children's and Special Needs Center/ State Attorney's Office	(305) 547-0160
City of Miami Police	(305) 579-6630
Community Health of South Dade, Inc. (CHI)	(305) 253-5100
Family Services	1(305) 359-1640
Fam. & Victim Services/Miami-Dade Domestic Intervention Program	(305) 571-7750
Florida Bar (Miami-Dade County)	(305) 377-4445
Gladstone Center for Girls	(305) 666-7228
Guardian Ad Litem Program	(305) 638-6861
Intensive Crisis Counseling Program (ICCP)	(North) (305) 624-7450 (South) (305) 264-6961
Juvenile Court Assessment Center (JCAC)	(305) 755-6200
Legal Aid	(305) 579-5733
Legal Services of Greater Miami, Inc.	(305) 576-0080
Mental Health Association	(305) 379-2673
Miami Children's Hospital	(305) 666-6511 (ext. 2456)
Miami-Dade Police	(305) 477-1112
Rape Treatment Center (RTC)	(305) 585-7273
State Attorney's Office (SAO)	(305) 547-0100

ABUSE

Therapeutic Services

Alliance for Psychological Services
(305) 663-6540

Catholic Charities Counseling & Emergency Services
(305) 758-0024
e-mail:counseling@catholiccharityedm.org

Center for Family & Child Enrichment
(305) 624-7450

Children's Psychiatric Center
(305) 274-3172 Sunset
(305) 828-1671 Hialeah
(305) 685-0381 North Dade

Douglas Gardens Community Mental Health Center
(305) 531-5341

Family Counseling Services of Greater Miami
(305) 271-9800

Family Life Center
(305) 666-9979

Homestead Behaviorial Clinic
(305) 248-3488

Jewish Family Services of Greater Miami (Main Office)
(305) 445-0555
www.seflin.org

Kristi House, Inc.
(305) 547-6800
www.kristihouse.org

HOMELESS SHELTERS FOR CHILDREN AND FAMILIES

Homeless Outreach Services

Within the city of Miami Beach
Douglas Gardens Outreach Services
701 Lincoln Road
Second Floor
Miami Beach, Fl
(305) 531-5341

North Kendall Drive South to SW 280 Street
Metatherapy Outreach Services
27940 South Dixie Highway
Naranja, Fl
(305) 247-1949

SW 280 Street South to Monroe County Line
Miami-Dade Office of Homeless Programs
Homestead/Florida City Neighborhood Center
1600 NW 6 Court
Florida City, Fl
(305) 247-2068

All Other Areas
Miami-Dade Office of Homeless Programs
860 NW 23 Street
Miami, Fl
(305) 638-6368

For pregnant adolescents in need of shelter, assess the family situation and offer counseling intervention to assist the family
Heaven of Hope
34 SW 5 Avenue
Florida City, Fl
(305) 247-3500 (for information on shelter & bed availability)

For general information about homeless education & awareness training contact:
(305) 995-7334

Jewish Vocational Service
736 NE 125 Street
N. Miami, Fl 33161
(305) 899-1587

HOMELESS SHELTERS FOR CHILDREN AND FAMILIES

Miami-Dade County

(From M-DCPS Homeless Children and Youth Program, September 20, 1999)

Cottages of Naranja
27940 S. Dixie Hwy.
Naranja, Fl 33032
(305) 247-1949
(305) 246-0025 Fax
Contact: Marlene Lee

Emergency Housing Center-North
2301 NW 54 Street
Miami, Fl 33142
(305) 638-6001
(305) 638-5608
Contact: Sheryl Hutchins

Emergency Housing Center-South
825 W. Drive, Unit 21
Florida City, Fl 33034
(305) 245-5011
(305) 242-7908 Fax
Contact: Annette Williams

Esperanza Center
1398 SW 1 Street
Miami, Fl 33135
(305) 642-2558
(305) 642-8036
Contact: Edeline Dureny or Orlando Lopez

Heaven of Hope
34 SW 5 Avenue
Florida City, Fl 33034
(305) 247-3500
(305) 246-4107
Contact: Mary Mayers

Homeless Assistance Center-North
1550 N. Miami Avenue
Miami, Fl 33132
(305) 329-3000
(305) 329-3051 Fax
Contact: Emma Rodriguez or Vyonda Moss

Homeless Assistance Center-South
28205 SW 125 Avenue
Miami, Fl 33033
(305) 416-7100
(305) 416-7265
Contact: Marilu Barreiro or Wanda Brunt

Inn Transition
(Located at Linda Lentin Elementary)
PO Box 610815
North Miami, Fl 33261
(305) 899-4601
(305) 899-4615 Fax
Contact: Joyce Henry

KIDSTART-Citrus Health, Inc.
4175 West 20 Avenue
Hialeah, Fl 33012
(305) 825-0300
(305) 821-0805 Fax
Contact: Betty Thomas

Miami Bridge-Central
2810 NW South River Drive
Miami, Fl 33125
(305) 635-8953
(305) 636-3521 Fax
Contact: Joan Shaw-Davis

Miami Bridge-South
326 NW 3 Avenue
Homestead, Fl 33030
(305) 246-8956
(305) 242-8222 Fax
Contact: Ana Gispert

Miami Rescue Mission
Women and Children's Center
2250 NW 1 Avenue
Miami, Fl 33127
(305) 571-2250
(305) 571-2248
Contact: Josie Merlet

Lutheran Services
16201 SW 95 Avenue, Suite 101
Miami, Fl 33127
(305) 256-6780
(3205) 256-6784 Fax
Contact: Edith Azael or Sandra Diaz

New Life Family Center
3620 NW 1 Avenue
Miami, Fl 33127
(305) 573-3333
(305) 576-5111 Fax
Contact: Doris Plumer

Safespace Shelter-North
Miami, Fl 33138
(305) 758-2546
(305) 756-1347 Fax
Contact: Oscie Fryer

Safespace Shelter-South
Homestead, Fl 33030
(305) 247-4249
(305) 245-1299 Fax
Contact: Terry Rabreau

Salvation Army
1907 NW 38 Street
Miami, Fl 33161
(305) 637-6720
(305) 635-1123 Fax
Contact: Michelle Lannuzzi

A Kid's Place
227 NE 17 Street
Miami, Fl 33132
(305) 379-2673
(305) 374-0027 Fax
Contact: Jamie Bravo or Angela Mitchell

INFORMATION AND ORGANIZATIONS FOR PARENTS

Information Sources

Central Directory
For Information about Services Available for Children & Adults with Disabilities
(305) 596-1160

Resident Guide to Local Services
Miami-Dade County Team Metro
(305) 375-5656

Organizations

Advocacy Center for Persons with Disabilities 1(800) 342-0823
e-mail:h.pendleton@advocacycenter.org

A.R.C. Project Thrive Kendall
11025 S.W. 84 Street, Cottage #7
Miami, FL 33173
(305) 279-4141

Association for Retarded Citizens, South Florida (A.R.C.)
5555 Biscayne Blvd.
Miami, FL 33137
(305) 759-8500

BayView Center for Mental Health Inc.
12550 Biscayne Blvd.
N. Miami, FL 33181
(305) 892-4600

Best Buddies Headquarters
100 S.E. 2 Street - Suite 1990
Miami, FL 33131
(305) 374-2233
(800) 89-BUDDY
www.bestbuddies.org

Camillus Health Concerns
708 N.E. 1 Avenue
Miami, FL 33132
(305) 577-4840

Caregivers Support Group
Women's Health Resource Cent.-Baptist Hosp.
Baptist Medical Arts Bldg. -1st Floor
8950 N. Kendall Drive
Miami, FL 33176
(305) 598-5981
www.baptisthealth.net

Catholic Family Services
For counseling (305) 758-0024

Catholic Legal Immigration Network
60 E. 3 Street - Suite #206
Hialeah, FL 33010
(305) 887-8333

Children's Medical Services (CMS)
(North) 1500 N.W. 12 Avenue - Suite 829
Miami, FL 33136
(305) 325-2830

(South) 3100 S.W. 62 Avenue, Cottage 5
Miami, FL 33155
(305) 669-6931

Community Blood Centers of South Florida
354 N.W. 1 Avenue
Homestead, FL 33030
(305) 326-8888
(Rental of infant/toddler car seats, minimal fee)

Compassionate Friends, Inc.
(305) 221-5184
(Anyone in a parental relationship with a child who has died)
e-mail: jtomeny@aol.com

Department of Children & Families
(305) 377-5068
(Client Relations Office)
(English & Spanish Information)
(referral to other numbers)

Department of Children & Families
11011 S.W. 104 Street
Miami, FL 33176
(305) 237-2161 (Classes for children)
(305) 237-2164 (Classes for adults)
(Continuing Education Classes)

Department of Children & Families
401 N.W. 2 Avenue
Miami, FL 33128
(305) 377-7087
(Developmental Services - Intake)

Department of Children & Families
(305) 243-5600 North
(305) 268-2611 South
(Early Intervention Services - Part C)

Disabled Parking Program
(305) 375-5678
(Parking permits are available from any tax collector or tag agent office)

Easter Seals
Miami-Dade
1475 N.W. 14 Avenue
Miami, FL 33125
(305) 325-0470
e-mail: essdade@aol.com

Epilepsy Foundation of South Florida
7300 N. Kendall Drive - Suite 700
Miami, FL 33156
(305) 670-4949
www.epilepsysofla.org

Exceptional Parent Magazine
PO BOX 3000
Dept. EP
Denville,NJ. 07834

Family Friends
395 N.W. 1 Street
Miami, FL 33128
(Volunteers 55+ years of age help families with disabled children)

Family Resource Center
9500 S. Dadeland Blvd.
Miami, FL 33156
(305) 576-6190
(parenting classes, support groups, counseling)

Family Services
444 Brickell Avenue - 4th Floor
Miami, FL 33130
(305) 358-1640
(12-17 years old)

Florida Association for the Gifted (FLAG)
Miami-Dade School District
1500 Biscayne Blvd. - Room 235
Miami, FL 33132

Florida Diagnostic & Learning Resources System/South (FDLRS/S)
5555 S.W. 93 Avenue
Miami, FL 33165
(305) 274-3501 (Miami-Dade)
(305) 293-1646 (Monroe)

Florida Directory/
Early Childhood Services
259 East 7 Avenue
Tallahassee, FL 32303
(800) 654-4440
(Monday-Friday 8:30 A.M-5:00 P.M.)
www.centraldirectory.org

Florida School for the
Deaf and Blind
207 N. San Marco Avenue
St. Augustine, FL 32084
(904) 823-4000
(904) 827-2200
(Free conferences & workshops for families)

Highland Park Pavilion
1660 N.W. 7 Court
Miami, FL 33136
(305) 545-2325
(Child and adolescent psychiatry)

Juvenile Rheumatoid Arthritis
(305) 374-0190 - FAX
(referral to volunteer number)

Legal Aid Society
123 N.W. 1 Avenue
Miami, FL 33128
(305) 579-5733

Legal Services
16201 S.W. 95 Avenue - Suite #301
Miami, FL 33157
(305) 232-9680
(305) 576-0080
(also Jewish Legal Services)

Mailman Center for Child Development
1601 N.W. 12 Avenue - Room 2025
Miami, FL 33136
(305) 243-5600
(Family Resource Room)

Make a Wish Foundation
P.O. Box 17377
Ft. Lauderdale, FL 33318
(954) 967-9474

Medicaid General Information
8355 N.W. 53 Street
Miami, FL 33166
(305) 499-2000

Medicaid Transportation
2775 S.W. 74 Avenue
Miami, FL 33155
(305) 263-7301

Miami-Dade County Citizen Services
140 West Flagler Street -#903
Miami, FL 33130
(305) 375-5656
(Consumer Services Department)
(Multi-page book of Miami- Dade resources free)

Miami-Dade County,
Youth & Family Development
11025 S.W. 84 Street
Miami, FL 33173
(305) 271-2211

Miami-Dade County Youth & Family Services
1701 N.W. 30 Avenue
Miami, FL 33125
(305) 633-6481

New Life Family Center
3620 N.W. 1 Avenue
Miami, FL 33127
(305) 573-3333

Parent Education Network On
Disabilities of Florida (PEN)
2735 Whitney Rd.
Clearwater, FL 33760
(800) 825-5736
www.fndfl.org

Parent to Parent of Miami
(305) 271-9797

Parents of the Visually Impaired
(305) 388-7497

South Florida Pre-School P.T.A.
15810 S.W. 88 Court
Miami, FL 33157
(305) 655-3656

South Miami Hospital/
Child Development Center
6200 S.W. 73 Street
Miami, FL 33143
(305) 663-5080
www.baptisthealth.net

Special Transportation Services
(305) 263-5406

Supplemental Security Income (SSI)
7000 S.W. 62 Avenue - Room 600
Miami, FL 33143
(800) 772-1213
(To apply for Medicaid and SSI)

Switchboard of Miami, Inc.
75 S.W. 8 Street
Miami, FL 33130
(305) 358-HELP (Crisis Line)
(AIDS and Crisis Counseling Referral)

Tourette Syndrome Association, Inc.
(407) 783-3248
E-mail:webmaster@tsa-fl.org

United Cerebral Palsy Assoc. of Miami (UCP)
1411 N.W. 14 Avenue
Miami, FL 33125
(305) 325-1080
www.ucpsouthflorida.org

United Way
1 S.E. 3 Avenue
Miami, FL 33131
(305) 860-3000

University of Miami/
Behavioral Medicine Center
P.O. Box 248185
Coral Gables, FL 33124-2070
(305) 284-4186

MISCELLANEOUS SERVICES FOR FAMILIES OF CHILDREN WITH DISABILITIES

Assistive Technology (A.T.) and Agencies that Help obtain A.T.

FAAST
5200 NE 2 Avenue
Miami, Fl 33137
(305) 762-1465
(800) 322-7881

FDLRS-South
5555 SW 93rd Avenue
Miami, Fl 33165
(305) 274-3501

Miami-Dade County Public Schools Prekindergarten Programs for Children with Disabilitites
5555 SW 93rd Avenue
Miami, Fl 33165
(305) 271-5701

Vocational Rehabilitation
4770 Biscayne Blvd
Suite 1260
Miami, Fl 33137
(305) 571-5666

Division of Blind Services
401 NW Second Avenue
Suite S-712
Miami, Fl 33138
(305) 377-5339

United Cerebral Palsy Association of Miami
1411 NW 14 Avenue
Miami, Fl 33125
(305) 325-1080

Make A Wish Foundation
PO Box 17377
Ft. Lauderdale, Fl 33318
(954) 967-9474

Job Accommodation Network
(1-800) 526-7234
(1-800) 232-9675 (ADA Information)

Alliance for Technology Access
(1-800) 455-7970

Equal Employment Opportunity Commission
(1-800) 669-3362
(1-800) 669-3301(TTY)

American with Disabilities Act – ADA in Action
(1-800) 949-4232

Central Directory Project
(305) 596-1160

Individual Colleges May Have Assistance For Individuals With Disabilities

MISCELLANEOUS SERVICES FOR FAMILIES OF CHILDREN WITH DISABILITIES

Developmental Services and Family Support

Developmental Services and Resources for Children and Adults who have Disabilities*, Such as Medical Equipment and Supplies, Certified Behavior Analysts, and Adult Day Training Program

Call the Office That Serves the Zip Code in Which You Live

Unit 601: 18301 N. Miami Avenue, Suite #230 Miami, Fl 33179
(305) 654-7073

33012 33014 33015 33016 33018 33054
33055 33056 33138 33141 33147 33150
33154 33160 33161 33162 33167 33168
33169 33179 33180 33181

Unit 602: 6600 SW 57 Avenue, Miami, Fl 33143
(305) 668-7263

33010 33109 33122 33125 33126 33127
33128 33129 33130 33131 33132 33134
33135 33136 33137 33139 33140 33142
33144 33145 33146 33149 33165 33166
33172 33174 33175 33178 33182 33184
33185 33192 33194

Unit 603: 12195 Quail Roost Drive, Building #2, Miami, Fl 33177
(305) 252-4482

33030 33031 33032 33033 33034 33035
33039 33133 33143 33155 33156 33157
33158 33170 33173 33176 33177 33183
33186 33187 33189 33190 33193 33196

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*Defined in Florida Statute 393 as Mental Retardation, Cerebral Palsy, Autism, Spinal Bifida, and Prader-Willie Syndrome.

MISCELLANEOUS SERVICES FOR FAMILIES OF CHILDREN WITH DISABILITIES

Developmentally Disabled Residential Intermediate Care

Miami Cerebral Palsy Residential Services
(305) 599-0899
(affiliate of United Cerebral Palsy of South Florida)
www.ucpsouthflorida.org

Administrative/Day Training Facility
2200 N.W. 107 Avenue
(305) 599-0899

Braddock Facility
14400 S.W. 32 Street
(305) 220-9599

80th Street Facility
11750 S.W. 80 Street
(305) 274-5014

2nd Street Facility
11801 N.W. 2 Street
(305) 220-2330

Sunset Facility
7100 S. W. 122 Ave.
(305) 275-1340

Home Nursing Care/Hospice
Check telephone Yellow Pages under **Nursing** heading.

Hospice is available through many hospitals. Check with your family physician.

National Hospice Organization
(800) 658-8898

National Resource Center for Respite & Crisis Care Services
800 Eastowne Drive,Suite 105
Chapel Hill, N.C. 27514
(800) 473-1727
(919) 490-5577
(919) 490-4905 **(FAX)**

Pediatric Medical Daycare/ Children's Rehab Network
8585 Sunset Drive
Miami,Fl.33143
(305) 270-9026

14 NE 6 ST
Homestead, Fl. 33030
(305) 245-9900

MISCELLANEOUS SERVICES FOR FAMILIES OF CHILDREN WITH DISABILITIES

Miami-Dade Leisure Access Programs/Parks

Miami-Dade Leisure Access Programs:

(305) 755-7800

- Adapted Aquatic Programs
- Blind & Visually Impaired
- Deaf
- Developmentally Disabled
- Tiny Tots
- Emotionally Handicapped
- Head Injury & Strokes
- Physically Disabled
- Senior
- Special Camps/SummerPrograms
- Miscellaneous Programs
- Rentals

www.co.miami-dade.fl.us/parks

Parks:

A.D. Barnes Leisure Access Center
3401 S.W. 72 Avenue
(305) 665-5319

Arcola Lakes Park
1301 N.W. 83 Street
(305) 836-5095

Black Point Park
24775 S.W. 87 Avenue
(305) 258-4092

Coral Reef Park
7895 S. W. 152 Street
(305) 235-1593

Crandon Park
4000 Crandon Boulevard
(305) 361-5421

Parks/Continued:

Dave & Mary Alper JCC
(Centro Comonitario Judio Dade-Campamento para niños con incapcidades)
(305) 271-9000, ext. 238

Deering Estate
16701 S.W. 72 Avenue

Haulover Park
10800 Collins Avenue
(305) 947-3525

Hialeah Park/City of
(Campamento de verano para niños con incapacidades)
(305) 824-5706

Homestead Bayfront Park
9698 SW 328 Street
(305) 230-3034

Kendall Indian Hammocks Park
11395 S.W. 79 Street
(305) 596-9324

International Tennis Center
7300 Crandon Boulevard
(305) 365-2300

Norwood Park
19401 N.W. 14 Avenue
(305) 653-3951

Oak Grove Park
690 N.E. 159 Street
(305) 944-8670

Red Berry's Baseball World
7455 S.W. 125 Avenue
(305) 279-2668
(Baseball Camp accepts children with disabilities)

Shake-A-Leg
(A unique sailing program for people with physical disabilities offers recreational and instructional programs for all skill levels.)
(305) 858-5550
www.shakealegmiami.org
e-mail: sal1miami@aol.com

South Dade Park
28151 S.W. 164 Avenue
(305) 247-9453

Southridge Park
S.W. 112 Avenue & 192 Street
(305) 238-4166

Special Olympics
(305) 406-9467
somd@bellsouth.net

Talking Books
(305) 751-8687
www.talkingbooks.com

Tamiami Park
11201 S.W. 24 Street
(305) 223-7072

Tropical Park
7900 S. W. 40 Street
(305) 226-8315

VIP Team
(Sponsored by American Soccer Association)
Saturday soccer for children with disabilities
Miller Park, Hammocks Park)
(305) 255-6394

Viscaya (Museum)
3251 South Miami Avenue
(305) 250-9133

Zoo (Miami-Dade Metrozoo)
12400 S.W. 152 Street
(305) 251-0400

MISCELLANEOUS SERVICES FOR FAMILIES OF CHILDREN WITH DISABILITIES

Recreation and Therapeutic Programs/ Respite Services/Transportation

Recreation and Therapeutic Programs:

Autism Society of America – So. Florida Chapter
(305) 681-4007, Ext 203
(305) 937-1416 Evenings

Big Brothers/Big Sisters
100 Almeria Avenue
(305) 441-9354

Dave & Mary Alper
Jewish Community Center
11155 S.W. 112 Avenue
(305) 271-9000
(Special Needs Camp & Programs)

Family Friends
(305) 347-4605

Genie's Workshop
19641 West Lake Drive
(305) 829-7693

Kiwanis Horses & Handicapped, Inc.
(305) 271-2210
(305) 274-6423

Peer Link Programs Inc.
(305) 408-0166

Talking Books
(305) 751-8687

Florida Elks Children's Therapy Service
(Free OT/PT services for Eligible families)
Program Administration (1-800) 523-1673
Chantal Salvane, PT (305) 278-2044

Respite Services:

Association for Retarded Citizens (ARC)
(305) 759-8500

Castleline Group Home
(305) 751-1524

Respite Services/Continued:

Give Me a Break
(Homestead)
(305) 273-3047

Marian Center
(305) 625-8354

The Possible Dream Foundation
(Down Syndrome)
(305) 252-2552

Sunrise Community
(305) 596-9040

United Cerebral Palsy (UCP)
(305) 325-1080

Transportation:

Miami-Dade Transit
(305) 770-3131
(Route Information)

Special Transportation Services (STS)
2775 S.W. 74 Avenue
(305) 263-5406

STS - Paratransit
2775 S.W. 74 Avenue
(305) 263-5400

GENERAL INFORMATION

Miami-Dade County Public Schools
Adult-Vocational Education Centers

American Adult
School Mail Code #7012
18350 N.W. 67 Avenue
Hialeah, FL 33015
(305) 557-3770

Baker Aviation Training
School Mail Code #7801
3725 N.W. 42 Avenue
Miami, FL 33142
(305) 871-3143

Coral Gables Adult
School Mail Code #7072
450 Bird Road
Coral Gables, FL 33146
(305) 443-4871

Dorsey Skill Center
School Mail Code #8139
7100 N.W. 17 Avenue
Miami, FL 33147
(305) 693-2490

English Center
School Mail Code #7841
3501 S.W. 28 Street
Miami, FL 33133
(305) 445-7731

Fienberg/Fisher Adult
School Mail Code #8221
1424 Drexel Avenue
Miami Beach, FL 33139
(305) 531-0451

Hialeah Adult
School Mail Code #7112
251 East 47 Street
Hialeah, FL 33013
(305) 822-1500

Hialeah-Miami Lakes Adult
School Mail Code #7132
7977 West 12 Avenue
Hialeah, FL 33014
(305) 823-1330

Lindsey Hopkins
750 NW 20th Street
Miami, Fl 33127
(305) 324-6070
(305) 545-6397 Fax

Miami Agricultural School
School Mail Code #7601
10200 N.W. 17 Avenue
Miami, FL 33147
(305) 696-6721

Miami Carol City Adult
School Mail Code #7232
3422 N.W. 187 Street
Opa Locka, FL 33054
(305) 621-5681

Miami Coral Park Adult
School Mail Code #7272
8865 S.W. 16 Street
Miami, FL 33165
(305) 226-6566

Miami Edison Adult
School Mail Code #7301
6161 N.W. 5 Court
Miami, FL 33127
(305) 751-7337

Miami Jackson Adult
School Mail Code #7342
1751 N.W. 36 Street
Miami, FL 33142
(305) 634-2641

Miami Lakes Technical
School Mail Code #8901
5780 N.W. 158 Street
Hialeah, FL 33014
(305) 557-1100

Miami Northwestern Adult
School Mail Code #7412
7007 N.W. 12 Avenue
Miami, FL 33150
(305) 836-0991

Miami Palmetto Adult
School Mail Code #7432
7460 S.W. 118 Street
Miami, FL 33156
(305) 235-1360

Miami Senior Adult
School Mail Code #7462
2450 S.W. 1 Street
Miami, FL 33135
(305) 649-9800

Miami Skill Center
School Mail Code #8991
50 N.W. 14 Street
Miami, FL 33136
(305) 358-4925

Miami Southridge Adult
School Mail Code #7732
19355 S.W. 114 Avenue
Miami, FL 33157
(305) 238-6110

Miami Springs Adult
School Mail Code #7512
751 Dove Avenue
Miami Springs, FL 33166
(305) 885-3585

Miami Sunset Adult
School Mail Code #7532
13125 S.W. 72 Street
Miami, FL 33183
(305) 385-4255

Morgan, Robert Vocational
School Mail Code #8911
18180 S.W. 122 Avenue
Miami, FL 33177
(305) 253-9920

North Miami Adult
School Mail Code #7592
800 N.E. 137 Street
North Miami, FL 33161
(305) 891-6590

South Dade Adult
School Mail Code #7702
109 N.E. 8 Street
Homestead, FL 33030
(305) 248-5723

South Dade Skill Center
School Mail Code #8981
28300 S.W. 152 Avenue
Leisure City, FL 33033
(305) 247-7839

Southwest Miami Adult
School Mail Code #7742
8855 S.W. 50 Terrace
Miami, FL 33165
(305) 274-0181

GENERAL INFORMATION

Miami-Dade County Public Schools
Community Schools

Allapattah Comm. School
School Mail Code #6011
1331 N.W. 46 Street
Miami, FL 33142
(305) 634-9787

Ben Franklin Comm. School
School Mail Code #2041
13100 N.W. 12 Avenue
North Miami, FL 33168
(305) 681-3547

Biscayne Comm. School
School Mail Code #0321
800 - 77 Street
Miami Beach, FL 33141
(305) 868-7722

Carver Comm. School
School Mail Code #6071
4901 Lincoln Drive
Coconut Grove, FL 33133
(305) 444-7388

Charles Drew Comm. School
School Mail Code #6141
1801 N.W. 60 Street
Miami, FL 33142
(305) 633-6057

Dunbar Comm. School
School Mail Code #1441
505 N.W. 20 Street
Miami, FL 33127
(305) 573-2344

Emerson Comm. School
School Mail Code #1641
8001 S.W. 36 Street
Miami, FL 33155
(305) 264-5757

Lillie Evans Comm. School
School Mail Code #1681
1895 N.W. 75 Street
Miami, FL 33147
(305) 691-4973

Fairlawn Comm. School
School Mail Code #1801
444 S.W. 60 Avenue
Miami, FL 33144
(305) 261-8880

Fienberg/Fisher Comm. School
School Mail Code #8221
1424 Drexel Avenue
Miami Beach, FL 33139
(305) 531-0419

Filer Comm. School
School Mail Code #6171
531 West 29 Street
Hialeah, FL 33012
(305) 822-6601

Hammocks Comm. School
School Mail Code #6221
9889 Hammocks Boulevard
Miami, Fl 33196
(305) 385-0896

Hialeah Comm. School
School Mail Code #6231
6027 East 7 Avenue
Hialeah, FL 33013
(305) 681-3527

Key Biscayne Comm. School
School Mail Code #2741
150 West McIntyre Street
Key Biscayne, FL 33149
(305) 361-5418

Kinlock Park Comm. School
School Mail Code #6331
4340 N.W. 3 Street
Miami, FL 33126
(305) 445-5467

Little River Comm. School
School Mail Code #3021
514 N.W. 77 Street
Miami, FL 33150
(305) 754-7531

Lorah Park Comm. School
School Mail Code #3041
5160 N.W. 31 Avenue
Miami, FL 33142
(305) 633-1424

Madie Ives Comm. School
School Mail Code #258l
20770 N.E. 14 Avenue
North Miami Beach, FL 33179
(305) 651-3155

McMillan Comm. School
School Mail Code #6441
13100 S. W. 59 Street
Miami, FL 33183
(305) 385-6877

Merrick Education Center
School Mail Code #9732
39 Zamora Avenue
Coral Gables, FL 33134
(305) 460-2903

Poinciana Park Comm. School
School Mail Code #4501
6745 N.W. 23 Avenue
Miami, FL 33147
(305) 691-5640

Ruben Dario Comm. School
School Mail Code #6121
350 N. W. 97 Avenue
Miami, FL 33172
(305) 226-0179

GENERAL INFORMATION

Clinic Sites
Community Outreach and WIC

Central Dade:

Bentley, Helen Family Health Center
3090 S.W. 37 Avenue
Miami, FL 33133
(305) 447-4950

Family Medical Center
1350 N.W. 14 Street
Miami, FL 33125
(305) 324-2443

Foreign Student Center
1080 Labaron Drive
Miami Springs, FL 33166
(305) 883-8856

Hialeah Family Health Center
901 E.10th Ave.
Hialeah, FL 33010
(305) 887-0004

Miami Beach Center
615 Collins Avenue
Miami, FL 33139
(305) 538-0525

Miami Children's Hospital
Continuing Care Clinic
6125 S.W. 31 Street
South Miami, FL 33155
(305) 666-6511

Myers, Stanley
Community Health Center
710 Alton Road
Miami Beach, FL 33140
(305) 538-8835

Riverside Elementary School
1190 S.W. 2 Street
Miami, FL 33130
(305) 547-1520

South Miami Health Center
6601 S.W. 62 Avenue
Miami, FL 33143
(305) 669-6903

Sweetwater Elementary
10655 S.W. 4 Street
Sweetwater, FL 33174
(305) 559-1101

North Dade:

James E. Scott (FHC)
7200 N.W. 22 Avenue
Miami, FL 33147
(305) 835-8122

Liberty City Health Services
1320 N.W. 62 Street
Miami, FL 33150
(305) 835-2200

Juanita Mann Center
7900 N.W. 27 Avenue
Suite #250
Miami, FL 33147
(305) 694-2900

North Dade Health Center
16555 N.W. 25 Avenue
Miami, FL 33150
(305) 621-8888

South Dade:

Community Health of South Dade (CHI)
10300 S.W. 216 Street
Miami, FL 33190
(305) 253-5100

Florida City Elementary
364 N.W. 6 Avenue
Florida City, FL 33034
(305) 247-4676

Hammocks Group Home
10810 S.W. 145 Place
Miami, FL 33186
(305) 382-7477

Martin Luther King Clinic
810 West Mowry Street
Homestead, FL 33030
(305) 248-4334

Model Medical Clinic/Deering Hospital
9299 S.W. 152 Street
Suite 100
Miami, FL 33157
(305) 548-7683

Naranja Elementary
13990 S.W. 264 Street
Naranja, FL 33032
(305) 258-3401

River Bend Group Home
15023 S.W. 149 Court
Miami, FL 33196
(305) 255-3210

WIC

WIC Breastfeeding Helpline
(305) 377-7272

WIC Program Office
(305) 377-7000

Women's Health
U.S. Public Health Service
(1-800) 994-9662
www.4woman.gov

GENERAL INFORMATION

Child Care Information

Catholic Charities
(305) 757-6241
Central Agency for Jewish Education
(305) 576-4030

Child Development/Child Care – Subsidized Child Care
Division of Miami-Dade,
Department of Human Resources
(305) 375-4670

Child Welfare League of America
440 First Street N.W.
Washington, D.C. 20001
(202) 638-2952
www.cwla.org

Children's Resources
8571 SW 112 St.
Miami,Fl. 33156
(305) 596-6966
crfcenter@aol.com

Family Central, Inc. – Subsidized Child Care
15804 N.W. 54 Avenue
Miami Lakes, FL 33014
(305) 908-7300
(305) 908-7373 **(FAX)**

Head Start/Miami-Dade Community Action Agency (CAA)
395 N.W. 1 Street
Miami, FL 33128
(305) 347-4628

National Association for the Education of Young Children (NAEYC)
1509 Sixteenth Street N.W.
Washington, D.C. 20036-1426
(800) 424-2460

National Conference for Community and Justice
(305) 670-6438

Pediatric Medical Daycare/Children's Rehab Network
8585 Sunset Drive
Miami, Fl. 33143
(305) 270-9026 or (305) 245-9900 Homestead

Children First Project **is a statewide legal effort dedicated to the enhancement of children's rights.**	Public Benefits, Food Stamps, WAGES, or Medicaid; Beneficios Publicos como cupestampillas de comida; Sipo piblik (food stamps)	Legal Services; Servicios Legales; Sevis Legal	Information Resources; Informacion en general; Resous pou infomasyon	Counseling/ Domestic Violence; Acesoria/ violencia domestic; Consej	Education; Educacion; Edikasyon	Shelter, Vivienda, Kay	Job Training/ Placement, Capacitacio Laboral, Preparasyon Travay	Child Care; Ciudado Infantil; Swyen pou timoun	Food, Clothing, Comida, Ropa, Manje, Rad	Rent Assistance, Assistencia para Vivienda, Aid pou lolye
Catholic Charities 9401 Bisc. Blvd., Miami, FL 33138 Contact: Reception (305) 758-0024 or 324-0014		X	X	X	X	X	X	X	X	X
Camillus House 336 N. W. 5 St. Miami, FL 33128 Contact: Elizabeth Gardin (305) 374-1065			X	X		X		X	X	
Dade Co. Bar Assn. Legal Aid Society 123 N.W. 1 Ave Miami, FL 33128 Contact: David Wolin, Esq. (305) 579-5733, ext. 2263		X								
Department of Children & Families 401 N.W. 2 Ave., Miami, FL 33128 Contact: Maria Gonzalez (305) 377-7540	X									
Florida Immigrant Advocacy Center 3000 Bisc. Blvd., Miami, FL 33137 Contact: Tom Zamorano (305) 573-1106	X									
Hispanic Coalition Corp. 5659 W. Flagler St., Miami, FL 33134 Contact: Rosa Kasse (305) 262-0060		X		X			X			
Homeless Trust 111 N.W. 1 St., Miami, FL 33128 Contact: Hilda Fernandez (305) 375-1490		X	X	X	X	X	X	X	X	X
Legal Services/Greater Miami, Inc. 3000 Bisc. Blvd., Miami, FL 33137 Contact: Dawn Miller, Esq. (305) 576-0080		X			X					
Lutheran Services 4343 W. Flagler St., Miami, FL 33134 Contact: Ali Paula (305) 567-2511		X	X	X	X	X	X	X	X	
M-D DHS, Office of Youth & Dev. 1701 N.W. 30 Ave., Miami, FL 33125 Contact: Elisa McCord (305) 633-6482, ext. 295			X	X	X	X	X	X	X	
Mujer, Inc. 211 S. H'stead Blvd., Miami FL 33030 Contact: Rocio Tafur-Salgado (305) 247-1388		X	X	X	X					
Redlands Christian Mig. Assoc. (RCMA) 13600 S.W. 312 St., Miami, FL 33030 Contact: Marbelia Zamarripa (305) 242-2575			X	X	X			X	X	

Current as of December 2000

2002
Monroe County
Community Health and Social Services

All information regarding Monroe County services is provided by:

Interagency Council, Inc.
P.O. Box 2224
Key West, FL 33045
Phone: (1) (305) 292-0204

The following legend will apply to all listed services for Monroe County:

***** - **Member of Interagency Council, Inc.**

L - **Lower Keys**

M - **Middle Keys**

U - **Upper Keys**

TDD - **Telecommunications Device for the Deaf**

Monroe County
Community Health & Social Services

Emergency Services:

Police, Fire & Ambulance
V/TDD - 911

Abuse Registry Hotline
(1)(800)96-ABUSE

American Red Cross*
L/M - (1)(305)296-3651
U - (1)(305)852-7616

Domestic Abuse Shelter
L - (1)(305)294-0824
M - (1)(305)743-4440
U - (1)(305)852-6222

Helpline*
(1)(305)296-4357
(1)(305)296-HELP
(1)(800)273-4558
(1)(305)292-8452 TDD

National Runaway Switchboard
(1)(800)621-4000

Poison Control
(1)(800)282-3171

U.S Coast Guard
(1)(305)295-9700

Wildlife Emergency Hotline
(1)(800)432-2046

Children's Services:

Big Brothers/Big Sisters of Monroe County*
(1)(305)294-9891

Boys & Girls Club of the Keys Area
(1)(305) 296-2258

Children's Medical Services
(1)(800)342-1898

Exceptional Student Education
(1)(305)293-1400

Children's Services/Continued

Family Resource Center*
(1)(305)292-6823

Florida Easter Seals Society-Keys Region
Early Intervention Program
(1)(305)295-0663
Teaching Little Children
(1)(305)295-0225

Florida Keys Healthy Coalition*
(1)(305)293-8424

Healthy Kids Insurance Connection
(1)(305)293-7570

Wesley House
Child Care Central Agency
(1)(305)292-7150
M - (1)(305)289-2675
U - (1)(305)853-3518
- (1)(877)595-KIDS

Healthy Families of Monroe
(1)(305)293-7547
(women, infants & children WIC)

Economic/Financial Assistance:

AIDS Help*
L - (1)(305)296-6196
M - (1)(305)289-0055

American Red Cross*
L - (1)(305)296-4033
M - (1)(305)296-4033
U - (1)(305)852-9612

Consumer Credit Counseling Service*
(1)(305)296-9502
(1)(800)928-2227

Department of Children & Families
(Child Support Enforcement)
(1)(800)622-5437

Economic/Financial Assistance.Continued:

Florida Keys Employment & Training Council*
V/TDD(1)(305)292-6762
M - (1)(305)289-2470

Florida Keys Outreach Coalition for the Homeless*
(Outreach Office)
(1)(305)293-0641
(Sunshine House)
(1)(305)293-0304

Food Stamps/AFDC
(1)(305)292-6719

Habitat for Humanity of Key West & Lower Keys
(1)(305)744-3460

Housing Authority*
L - (1)(305)296-5621
M - (1)(305)743-5765
U - (1)(305)453-9200

Keys Cancer Center
(305)296-0021

Job Service of Florida
V/TDD(1)(305)292-6762

Medicaid Information
L - (1)(305)293-6308
(1)(800)953-0555

Medicare Information
(1)(800)772-1213

Monroe County Social Services*
L (1)(305)292-4408/TDD(305) 292-4412
M - (1)(305)289-6016/TDD(305)289-6316
U - (1)(305)852-7125/TDD(305)853-7321

Social Security
V/TDD(1)(800)325-0778

The Salvation Army*
L - (1)(305)294-5611
M - (1)(305)743-9410
U - (1)(305)743-9410

Economic/Financial Assistance Continued:

Unemployment Compensation
(1)(305)292-6762

Veterans Affairs
L - (1)(305)295-5150
(1)(800)827-1000

Wesley House Family Resource Center
(305)292-6823, Ext 24

Worker's Compensation
(1)(800)342-1741

Educational/Recreational:

American Red Cross*
L - (1)(305)296-4033
M - (1)(305)296-4033
U - (1)(305)852-9612

City of Key West
(1)(305)292-8200

Family Resource Center*
(1)(305)292-6823

Florida Keys Community College
L - (1)(305)296-9081
M - (1)(305)743-2133
U - (1)(305)852-2737

Florida Keys Employment & Training Council*
L - (1)(305)292-6762
M - (1)(305)289-2470
U - (1)(305)289-2470

Literacy Volunteers of America*
L - (1)(305)294-4352
M - (1)(305)289-2450
U - (1)(305)852-2633

Monroe County Cooperative Extension Service*
L - (1)(305)292-4501

Monroe County Library
L - (1)(305)292-3595
M - (1)(305)743-5156
U - (1)(305)451-2396

Educational/Recreational/ Continued:

Monroe County School Board
(1)(305)293-1400

Pace Center for Girls
L (305)293-1892
M (305)743-7703
U (305)853-1007

St. Leo College
(305)293-2847
1-(877)595-KIDS

Wesley House Child Care Services
L (305) 292-7150
M (305)289-2675
U (305)853-3518

Health Care:

AIDS Help*
(1)(305)296-6196

American Cancer Society
(1)(305)294-9385

Community Blood Centers of Florida*
(1)(305)294-7668

Fisherman's Hospital (Marathon)
(305)743-5533

Griswold Special Care*
L - (1)(305)296-9997
M - (1)(305)743-3373
U - (1)(305)852-0699

Health Care Center
L - (305)292-6885
M (305)289-2730
U (305)853-3240

Healthy Start Program
L (305)293-7515

Hospice of the Florida Keys *
L - (1)(305)294-8812

Kessler RMS Therapy Center
(305)292-1805

Health Care/Continued:

Key West Convalescent Center
(305)296-2459

Key West Orthopedics
(305)295-9697

Keys Cancer Center*
(1)(305)296-0021

Key West Convalescent Center
(1)(305)296-2459

Lion's Eye Clinic
(305)296-5466

Mariner's Hospital (Islamorada)
(1)(305)852-4418

Medivan Information
(1)(305)797-4104

Monroe County Health Department
L (1)(305)292-6894
M (1)(305)289-2450
U (1)(305)853-3240

Navy Branch Medical Clinic
(1)(305)293-4500

Primary Care – Indigent Care at Key West Hospital
(1)(305)294-5531

Roosvelt Sands Health Clinic
(1)(305)293-1741

Rural Health Network*
(1)(305)293-7570

Staff Builders Home Health Services*
- (1)(305)296-6410

VA Outpatient Clinic
(1)(305)293-4810

Visiting Nurses Association
L - (1)(305)294-8812
M/U- (1)(305)743-9048

Law Enforcement & Military:

Florida Marine Patrol
(1)(305)289-2320

Key West Police Department*
(1)(305)294-2511

Monroe County Sheriff's Dept.
L - (1)(305)296-2424
M - (1)(305)289-2430
U - (1)(305)853-3211
(1)(800)273-COPS

Legal/Consumer Services:

Attorney General/Victim Advocate
(1)(800)226-6667

Circuit Court, Guardianship*
(1)(305)292-4323

City of Key West
(1)(305)292-8200

Consumer Complaints
(1)(800)435-7352

Crime Compensation Bureau
(1)(800)226-6667

Dept. of Corrections/Probation
L - (1)(305)292-6742
M - (1)(305)289-2340
U - (1)(305)853-3262

Driver's License
M - (1)(305)289-2306
U - (1)(305)853-3562

Guardian Ad Litem Program
(1)(305)292-3485

Immigration & Naturalization
(1)(305) 536-5741

Lawyer Referral
(1)(800)342-8011

Legal Services/Florida Keys
(1)(305)292-3566

Legal/Consumer Services/Continued:

National Association for the Advancement of Colored People (NAACP)*
(1)(305)295-9205

State Attorney's Office/Victim's Advocate
L - (1)(305)292-3400
M - (1)(305)743-9471
(1)(305)745-0136 Pager
U - (1)(305)289-2593

Care Center for Mental Health*
(1)(305)292-6843

Comprehensive Psychiatric Center
(1)(305)743-8176

Florida Keys Outreach Coalition
(1)(305)295-7580

Guidance Clinic of Middle Keys*
(1)(305)289-6150

Helpline, Inc.
(1)(305)296-HELP(4537

The Heron (ACLF)*
(1)(305)743-4129

Nat'l Alliance for the Mentally Ill
(1)(305)294-4875

Key West Housing Authority
(1)(305)292-1505

Teen Line
(1)(305)292-8440

Military

Key West Auxiliary-Navy-Marine Corps Relief
(1)(305)293-2169

NAS Family Service Center
(1)(305)293-4408

Navy Branch Medical Clinic
(1)(305)293-4500

Services For Adults:

American Association of Retired Persons (AARP)
(1)(305)292-3565

Bayshore Manor
(1)(305)294-4966

Department of Children and Families – Aging and Adult Services
(1)(305)292-6782

Columbia Deering Hospital PHP*
(1)(305)664-3535

Social Security
V/TDD (1)(800)325-0778

Medicare
(1)(800)772-1213

Special Needs:

The Able Network/Information & Referral for Disabled
(1)(888)838-2253

Birth & Death Certificates
(1)(305)292-6894

Blind Services
L - (1)(305)292-6762
M - (1)(305)289-2470
U - (1)(305)853-3540

Child Find
(1)(305)293-1646

Florida Easter Seals Society*
(1)(305)294-1089 V/TDD

Florida Keys Employment & Training Council
L - (1)(305)292-6762 V/TDD
M - (1)(305)289-2470

Florida Keys Deaf Services*
(1)(305)296-4357
(1)(305)292-8452 TDD

Griswold Special Care*
L - (1)(305)296-9997
M - (1)(305)743-3373

Marathon Adult Day Center
(1)(305)743-0996

Medicaid Information
(1)(305)292-6719
- (1)(800)953-0555

Kessler RMS Therapy Center
(1)(305)292-1805

Lions Eye Clinic
(1)(305)296-5466

Florida Keys Employment & Training Douncil
L - (1)(305)292-6762V/TDD
M - (1)(305)289-2470
U - (1)(305)853-3540

Florida State Relay
(telephone for deaf)
(1)(800)955-8770
(1)(800)955-8771

Monroe Association for Retarded Citizens (MARC)
(1)(305)294-9526

TDD Repair
(1)(800)222-3448

Vocational Rehabilitation
(1)(305)292-6763

Support Groups:

AIDS/HIV Support/Caregiver
(1)(305)296-6196

Al-Anon
(1)(305)296-4357
(1)(800)273-4558

Alcoholics Anonymous
L - (1)(305)296-8654
M - (1)(305)743-3262
(1)(800)252-6465

American Cancer Society
(1)(305)294-9385
M - (1)(305)274-9315
U - (1)(305)930-9227

Support Groups/Continued:

Co-Dependency Anonymous
(1)(305)296-4357

Diabetic Support Group
(1)(305)294-5531

Eating Disorders
(1)(305)296-4357

Helpline
(1)(305)296-HELP (4357)

Narcotics Anonymous
(1)(305)296-7999

National Alliance for the Mentally Ill (NAMI)
(1)(305)294-4875

Parkinson's Support Group
(1)(305)294-2591

Weather:

Forecast and Information
(1)(305)294-1122

**For all other support groups,
call the Helpline:
(1)(305) 296-4357
(1)(305) 296-HELP**

FLORIDA LOCAL AND TOLL FREE NUMBERS

Advocacy Center for Persons With Disabilities
(800) 342-0823
www.advocacycenter.org

Department of Agriculture & Consumer Services
(800) 435-7352

Blind Services
(800) 342-1828
www.state.fl.us/dbs/

Center for Autism & Related Disabilities (C.A.R.D.)
(305) 284-6563

Child/Adult Abuse
(800) 342-9152

Department of Children & Families
Client Relations Office
(305) 377-5068

Comprehensive Cancer Center
(800) 422-6237

Epilepsy Foundation of America
(800) 332-1000

Family Network on Disabilities of Florida
(800) 825-5736
www.fndfl.org

Florida Dental Association
(800) 877-9922
www.floridadental.org

National Organization of Rare Disorders (N.O.R.D.)
(800) 447-6673

Department of Professional Business & Regulation
(800) 342-7940

OTHER IMPORTANT NUMBERS

Exceptional Student Education Program Development & Services Section/ Bureau of Instructional Support & Community Services/ Florida Department of Education
(850) 488-1106
www.firn.edu/doe

Office for Civil Rights/U.S.A. Region IV/Dept. of Education
(404) 562-6350

Safe and Drug Free Schools
(850) 488-1570
www.firn.edu/doe/commhome

NICHCY

National Information Center
for
Children and Youth with
Disabilities
P.O. Box 1492
Washington, D.C. 20013-1492
http://www.nichcy.org

UNITED STATES SENATORS
Honorable Bob Graham (D)
United States Senate
524 Hart Senate Office Bldg.
Washington, DC 20510-0903
(202) 224-3041;
(202) 224-5621 (TTY)
(202) 224-2237 (Fax)
E-mail: bob_graham
@graham.senate.gov
Web: www.senate.gov/~graham

Honorable Bill Nelson (D)
United States Senate
Washington, DC 20510
(202) 224-5274
(202) 224-8022 (Fax)
Web:billnelson.senate.gov/
index.html

GOVERNOR
Jeb Bush
The Capitol
Tallahassee, FL 32399-0001
(850) 488-4441
(850) 487-0801 (fax)
Web: fcn.state.fl.us/eog

STATE DEPT. OF EDUCATION: SPECIAL EDUCATION
Shan Goff, Chief
Bureau of Instructional Support & Community Services
Division of Public Schools & Community Education
Department of Education
325 West Gaines Street, Suite 614
Tallahassee, FL 32399-0400
(850) 488-1570
E-mail: goffs@mail.doe.state.fl.us
Web: www.firn.edu/doe/commhome

PROGRAMS FOR CHILDREN WITH DISABILITIES: AGES 3 THROUGH 5
Susan Menchow, Administrator
Florida Partnership for School Readiness
600 S. Calhoun Street
Holland Bldg, Room 251
Tallahasse, FL 32399-0001
(850) 488-0337
Web: www.schoolreadiness.org

PROGRAMS FOR INFANTS AND TODDLERS WITH DISABILITIES: AGES BIRTH THROUGH 2
Mike Haney, Division Director
Prevention and Interventions Unit
Childrens Medical Services,
Dept. of Health
4052 Bald Cypress Way, Bin A-06
Tallahassee, FL 32399-1707
(850) 245-4200
E-mail: Mike_Haney@doh.state.fl.us

STATE DIVISION OF VOCATIONAL REHABILITATION

Carl F. Miller, Jr., Director
Division of Vocational
Rehabilitation Services
Department of Education
2002 Old St. Augustine Road,
Building A
Tallahassee, FL 32301-4862
(850) 488-6210
Web: www2.myflorida.com/doe/vr

OFFICE OF STATE COORDINATOR OF VOCATIONAL EDUCATION FOR STUDENTS WITH DISABILITIES

Janet Adams, Program Specialist
Division of Workforce Development
Department of Education,
Turlington Building
325 W Gaines Street, Room 701
Tallahassee, FL 32399-0400
(850) 487-3164
E-mail: adamsj@mail.doe.state.fl.us
Web: www.firn.edu/doe/workforce

STATE MENTAL HEALTH AGENCY

Celeste Putnam, Director
Mental Health Programs Office
Department of Children & Families
1317 Winewood Blvd., Bldg. 6
Tallahassee, FL 32399-0700
(850) 488-8304

STATE MENTAL HEALTH REPRESENTATIVE FOR CHILDREN AND YOUTH

Sue Ross, Chief
Children's Mental Health Program
Mental Health Programs Office
1317 Winewood Blvd.,
Bldg. 6, Room 290
Tallahassee, FL 32399-0700
(850) 488-8304
E-mail: sue_ross@dcf.state.fl.us
Web: www.state.fl.us/cf_web/

STATE DEVELOPMENTAL SERVICES

Darlene Golden, Assistant Secretary
Department of Children and Families
Developmental Disabilities
Programs Office
1317 Winewood Blvd.,
Bldg. 3, Rm. 325
Tallahassee, FL 32399-0700
(850) 488-4257
E-mail:
darlene_golden@dcf.state.fl.us

STATE DEVELOPMENTAL DISABILITIES PLANNING COUNCIL

Joseph Krieger, Director
Florida DD Council
124 Marriott Drive, Suite 203
Tallahassee, FL 32301-2981
(850) 488-4180
E-mail: joek.fddc@nettally.com
Web: www.fddc.org

PROTECTION & ADVOCACY AGENCY

Gary Blumenthal, Executive Director
Advocacy Center for
Persons with Disabilities
2671 Exec. Cntr. Cir. West, Suite 100
Tallahassee, FL 32301-5029
(850) 488-9071;
(800) 346-4127 (TTY)
(800) 342-0823;
(800) 350-4566
(Spanish & Creole Speaking Clients)
E-mail: advocacyn@aol.com
Web: www.AdvocacyCenter.org

CLIENT ASSISTANCE PROGRAM

Ann Robinson, CAP Prog. Director
Contact Protection & Advocacy
Agency
(see above)

PROGRAMS FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

John Agwunobi, M.D., M.B.A.,
Deputy Secretary
Children's Medical Services
Department of Health
4052 Bald Cypress Way, Bin A-06
Tallahassee, FL 32399-1707
(850) 245-4200

STATE AGENCY FOR VISUAL IMPAIRMENTS

David Newton, Program Specialist
Division of Blind Services
Department of Education
2551 Executive Center Circle West,
Suite 200, Lafayette Bldg.
Tallahassee, FL 32399
(850) 488-1330
E-mail: david_newton@fdles.state.us

PROGRAMS FOR CHILDREN & YOUTH WHO ARE DEAF OR HARD OF HEARING

Cecil Bradley, VR Administrator
Deaf & Hard of Hearing Services and
School-to-Work Transition Programs
Division of Vocational Rehabilitation
2002 Old St. Augustine Road, Bldg A
Tallahassee, FL 32301
(850) 488-8380 (V);
(850) 413-9629 (TTY)
E-mail: bradlec@vr.fdles.state.fl.us

STATE EDUCATION AGENCY RURAL REPRESENTATIVE

David Ashburn, Deputy Director
Instructional Programs
Division of Public Schools &
Community Education
Department of Education
Florida Education Center, Room 514
Tallahassee, FL 32399
(850) 488-2601

REGIONAL ADA TECHNICAL ASSISTANCE AGENCY

Southeast Disability & Business
Technical Assistance Center
(SEDBTAC), Region 4
490 10th Street
Atlanta, GA 30318
(404) 385-0636 (V/TTY);
(800) 949-4232
E-mail: se-dbtac@mindspring.com
Web: www.sedbtac.org

DISABILITY ORGANIZATIONS

Attention Deficit Disorder

To identify an ADD group in your state or locality, contact either:

Children & Adults with Attention-Deficit/Hyperactivity Disorder
(CHADD)
8181 Professional Place, Suite 201
Landover, MD 20785
(301) 306-7070
(800) 233-4050
(Voice mail to request information packet)
E-mail: national@chadd.org
Web: www.chadd.org

National Attention Deficit
Disorder Association (ADDA)
1788 Second Street, Suite 200
Highland Park, IL 60035
(847) 432-2332
E-mail: mail@add.org
Web: www.add.org

Autism

Autism Society of Florida, Inc.
P.O. Box 266823
Weston, FL 33326
(954) 349-2820
Web: www.autismfl.com

Brain Injury

Brain Injury Association of Florida (BIAF)
North Broward Medical Center
201 East Sample Road
Pompano Beach, FL 33064
(954) 786-2400;
(800) 992-3442 (in FL)
E-mail: info@biaf.org
Web: www.biaf.org

Cerebral Palsy

Gloria Wetherington,
President of the Board of Directors
United Cerebral Palsy of Florida
1830 Buford Ct.
Tallahassee, FL 32308
(850) 922-5630

Epilepsy

Epilepsy Services of Southwest Florida
1900 Main Street, Suite 212
Sarasota, FL 34236-8545
(941) 953-5988
E-mail: epilepsy@gte.net

Susan Ladd
Epilepsy Program
FL Department of Health, HSFCD
4052 Bald Cypress Way, Bin A-18
Tallahassee, FL 32399-1744
(850) 245-4330
E-mail: Susan_Ladd@doh.state.fl.us
Web: www.doh.state.fl.us/

Learning Disabilities

Learning Disabilities Association of Florida (LDAF)
331 East Henry Street
Punta Gorda, FL 33950
(941) 637-8957
E-mail: lda00@sunline.net

Mental Health

Faye Barnette, Executive Director
NAMI-Florida
1020 E. Lafayette, Suite 102
Tallahassee, FL 32301
(850) 671-4445
E-mail: namifl@unr.net
E-mail: faye@namifl.org
Web: www.nami.org

Mental Retardation

Chris Schuh, Executive Director
Association for Retarded Citizens/FL
411 East College Avenue
Tallahassee, FL 32301
(850) 921-0460
E-mail: arcfl@supernet.net
Web: www.arcflorida.org

Speech and Hearing

FL Lang., Speech & Hearing Assoc.
335 Beard Street
Tallahassee, FL 32303
(850) 222-6000
E-mail: mark@hmgnet.com

Spina Bifida

Patrick Sabadie, Executive Director
Spina Bifida Association of FL, Inc.
24 Beach Walker Rd.
Fernandina Beach, FL 32034-6600
(904) 261-6639;
(800) 722-6355 (in FL only)
E-mail: psabadie@net-magic.net

Visual Impairments

Frances Mary D'Andrea, Director
American Foundation for the Blind/Southeast
100 Peachtree Street, Suite 620
Atlanta, GA 30303
(404) 525-2303
E-mail: atlanta@afb.net
Web: www.afb.org

UNIVERSITY CENTERS FOR EXCELLENCE IN DEVELOPMENTAL DISABILITIES
(formerly University Affiliated Programs)
Daniel Armstrong, Director
Mailman Center for Child Dev.
Univ. of Miami/School of Medicine
P.O. Box 016820 - D-820
Miami, FL 33101
E-mail: darmstrong@miami.edu
Web: http://pediatrics.med.miami.edu

TECHNOLOGY-RELATED ASSISTANCE
Terry Ward, Director
Florida Alliance for Assistive Service and Technology
1020 E. Lafayette Street, Suite 110
Tallahassee, FL 32301-4546
(850) 487-3278
E-mail: faast@faast.org
Web: faast.org

PARENT TRAINING AND INFORMATION PROJECT
Jan LaBelle, Executive Director
Family Network on Disabilities of Florida, Inc.
2735 Whitney Road
Clearwater, FL 33760-1610
(727) 523-1130; (800) 825-5736
E-mail: fnd@fndfl.org
Web: fndfl.org/

PARENT-TO-PARENT
Karen Clay, Director
Parent to Parent of Florida
Family Network on Disabilities of Florida, Inc.
2735 Whitney Road
Clearwater, FL 33760
(727) 523-1130;
(800) 825-5736
E-mail: mikesmom3@aol.com
Web: http://fndfl.org/

COMMUNITY PARENT RESOURCE CENTER
Isabelle Garcia, Executive Director
Parent to Parent of Miami, Inc.
Community Parent Resource Center
c/o Sunrise Community
9040 Sunset Drive, Suite G
Miami, FL 33173
(305) 271-9797;
(800) 527-9552
E-mail: PtoP1086@aol.com

PARENT TEACHER ASSOCIATION (PTA)
Patty Hightower, President
Florida Congress of Parents and Teachers, Inc.
1747 Orlando Central Parkway
Orlando, FL 32809-5757
(407) 855-7604
E-mail: janice@floridapta.org
Web: www.floridapta.org

OTHER DISABILITY ORGANIZATIONS

Easter Seals Florida
Robert Griggs, President
1040 Woodcock Road, Suite 215
Orlando, FL 32803
(407) 896-7881
E-mail: rgriggs@fl.easter-seals.org
E-mail: info@fl.easter-seals.org

Florida Assoc. Rehab. Facilities, Inc.
Terry R. Farmer, President & CEO
2475 Apalachee Parkway, Suite 205
Tallahassee, FL 32301-4946
(850) 877-4816
E-mail: tfarmer@floridaarf.org
Web: www.respectofflorida.org

VSA (Very Special Arts) Florida
Gay Drennon, Executive Director
3500 E. Fletcher Avenue, Suite 225
Tampa, FL 33613
(813) 975-6962
E-mail: drennon@earthlink.net
Web: www.vsafl.org

AGE OF ELIGIBILITY

Each state sets eligibility ages for services to children and youth with disabilities. For current information concerning this state, please contact the office listed under
**STATE DEPARTMENT OF EDUCATION:
SPECIAL EDUCATION.**

ABOUT NICHCY STATE RESOURCE SHEETS

NICHCY State Resource Sheets are listings of selected state-wide organizations that can refer people to organizations in their area. We update the state sheets continuously; however, the addresses and telephone numbers of these selected groups are constantly changing. If you find that an address or number has changed or is incorrect, please e-mail us at nichcy@aed.org and let us know.

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National Information Center
for Children and Youth
with Disabilities

NICHCY

P.O. Box 1492
Washington, DC
20013-1492
E-Mail: nichcy@aed.org
Web: www.nichcy.org
1-800-695-0285 (Voice/TTY)

National Toll-Free Numbers

The following is a selected list of toll-free numbers for national organizations concerned with disability and children's issues. Inclusion on this list does not imply endorsement by NICHCY or the Office of Special Education Programs. There are also many national disability organizations providing services and information which do not have toll-free numbers. If you would like additional help in locating assistance, contact NICHCY at 1-800-695-0285 (Voice/TTY).

Note: Telephone numbers are designated either Voice (V) or Text Telephone (TTY), indicating their accessibility to TTY users.

AIDS

CDC National Prevention Information Network
1(800) 458-5231 (V; English/Spanish)
1(800) 243-7012 (TTY)

CDC National STD and AIDS Hotline
1(800) 342-2437 (V)
1(800) 344-7432 (V; Spanish)
1(800) 243-7889 (TTY)

Hemophilia and AIDS/HIV Network for Dissemination of Information
1(800) 424-2634 (V)

HIV/AIDS Treatment Information Service
1(800) 448-0440
1(888) 480-3739 (TTY)

IDS Clinical Trials Information Services
1(800) 874-2572
1(888) 480-3739 (TTY)

National Pediatric and Family HIV Resource Center
1(800) 362-0071

ALCOHOL AND OTHER DRUG ABUSE

American Council for Drug Education
1(800) 378-4435

Families Anonymous
1(800) 736-9805

National Council on Alcoholism and Drug Dependence
1(800) 622-2255

National Institute on Drug Abuse Helpline
1(800) 662-4357 (V)

OSAP National Clearinghouse for Alcohol and Drug Information
1(800) 729-6686 (V)
1(800) 487-4889 (TTY)

AMERICANS WITH DISABILITIES ACT (ADA)

ADA in Action
1(800) 949-4232

Disability Rights Education and Defense Fund ADA Technical Assistance Information Line
1(800) 466-4232 (V/TTY)

Disability and Business Technical Assistance Centers
1(800) 949-4232 (V/TTY)

Equal Employment Opportunity Commission
1(800) 669-3362 (V)
1(800) 800-3302 (TTY)

Job Accommodation Network
1(800) 526-7234 (V/TTY)
1(800) 232-9675 (V/TTY; ADA Information)

U.S. Architectural and Transportation Barriers Compliance Board -- Access Board
1(800) 872-2253 (V)
1(202) 272-5449 (TTY)
1(800) 993-2822 (TTY)

U.S. Department of Housing and Urban Development -- HUD User
1(800) 245-2691 (V)

ASSISTIVE TECHNOLOGY/DEVICES

AAT Advanced American Telephone
1(800) 233-1222 (V)
1(800) 896-9032 (TTY)

AbleNet
1(800) 322-0956 (V)

Alliance for Technology Access
1(800) 455-7970

Chrysler Corporation Automobility Program
1(800) 255-9877

IBM Special Needs Systems
1(800) 426-4832 (V)
1(800) 426-4833 (TTY)

TECHKNOWLEDGE
1(800) 726-9119
1(404) 894-4960 (V; Atlanta Metro Area)

BLINDNESS/VISUAL IMPAIRMENTS

American Council of the Blind
1(800) 424-8666 (V/TTY)

American Foundation for the Blind
1(800) 232-5463

American Printing House for the Blind
1(800) 223-1839

Blind Children's Center
1(800) 222-3566 (V)

Hadley School for the Blind
1(800) 323-4238 (V)

Library Reproduction Service (LRS)
1(800) 255-5002

Lighthouse National Center for Vision and Child Development
1(800) 334-5497 (V)
1(212) 821-9713 (TTY)

National Association for Parents of Children with Visual Impairments
1(800) 562-6265

National Library for the Blind and Physically Handicapped
1(800) 424-8567 (V)
1(800) 424-9100 (TTY, English)
1(800) 345-8901 (TTY, Spanish)

Prevent Blindness America
1(800) 221-3004 (V)

Recording for the Blind & Dyslexic
1(800) 803-7201 (V)

The Foundation Fighting Blindness
1(888) 394-3937 (V)
1(800) 683-5551 (TTY)

BURNS

Phoenix Society for Burn Survivors
1(800) 888-2876 (V)

CANCER

American Cancer Society
1(800) 227-2345

Cancer Information and Counseling Line
1(800) 525-3777 (V)

Candlelighters Childhood Cancer Foundation
1(800) 366-2223 (V)

National Brain Tumor Foundation
1(800) 934-2873

National Cancer Information Service
1(800) 422-6237 (V; English/Spanish)
1 (800) 332-8615 (TTY)

CHILD ABUSE

Clearinghouse on Child Abuse and Neglect/Family Violence Information
1(800) 394-3366 (V)

Prevent Child Abuse America
1(800) 244-5373

CHILD CARE

National Resource Center for Health and Safety in Child Care
1(800) 598-5437

COMMUNICATION DISORDERS

Communication Aid Manufacturers' Association
1(800) 441-2262

National Institute on Deafness and Other Communication Disorders Clearinghouse
1(800) 241-1044 (V)
1(800) 241-1055 (TTY)

National Center for Stuttering
1(800) 221-2483

National Stuttering Association
1(800) 364-1677

CRANIOFACIAL SYNDROMES

Children's Craniofacial Association
1(800) 535-3643 (V)

FACES -- National Craniofacial Association
1(800) 332-2373 (V)

DEAFNESS/HEARING IMPAIRMENTS

American Society for Deaf Children
1(800) 942-2732 (V/TTY)

Better Hearing Institute
1(800) 327-9355 (V/TTY)

Deafness Research Foundation
1(800) 535-3323 (V/TTY)
1(212) 684-6559 (V/TTY; in NY)

Hear Now
1(800) 648-4327 (V/TTY)

John Tracy Clinic
1(800) 522-4582 (V/TTY)
1(213) 748-5481 (V; in 213 area)
1(213) 747-2924 (TTY; in 213 area)

National Cued Speech Association
1(800) 459-3529

National Hearing Aid Society
1(800) 521-5247 (V)

National Information Clearinghouse on Children Who are Deaf-Blind (DB-LINK)
1(800) 438-9376 (V)
1(800) 854-7013 (TTY)

National Institute on Deafness and Other Communication Disorders Clearinghouse
1(800) 241-1044 (V); 1(800) 241-1055 (TTY)

DISABILITY AWARENESS

Kids on the Block
1(800) 368-5437

EDUCATION

American Association for Vocational Instructional Materials
1(800) 228-4689 (V)

American School Counselor Association
1(800) 306-4722

Association for Childhood Education International
1(800) 423-3563 (V)

National Center for School Leadership
1(800) 643-3205 (V)

Urban Special Education Leadership Collaborative
1(800) 225-4276

U.S. Office of Educational Research and Improvement
1(800) 424-1616 (V)

EMPLOYMENT

Equal Employment Opportunity Commission
1(800) 669-3362 (V)1(800) 800-3302 (TTY)

Job Accommodation Network
1(800) 526-7234 (V/TTY)
1(800) 232-9675 (V/TTY; ADA Information)

FINANCIAL COUNSELING

National Foundation for Consumer Credit
1(800) 388-2227 (V)

HOSPICE

Children's Hospice International
1(800) 242-4453 (V/TTY)

HOSPICELINK
1(800) 331-1620

INFORMATION SERVICES

ABLEDATA/National Rehabilitation Information Clearinghouse
1(800) 227-0216 (V/TTY)

ACCESS ERIC
1(800) 538-3742 (V)

Easter Seals-National Office
1(800) 221-6827 (V)
1(312) 726-4258 (TTY)

ERIC Clearinghouse on Disabilities and Gifted Education
1(800) 328-0272 (V/TTY)

The Genetic Alliance
1(800) 336-4363

National Clearinghouse for Professions in Special Education
1(800) 641-7824
1(703) 264-9480 (TTY)

National Information Center for Children and Youth with Disabilities
1(800) 695-0285 (V/TTY)

National Information Clearinghouse for Infants with Disabilities and Life Threatening Conditions
1(800) 922-9234, ext. 201 (V/TTY)
1(800) 922-1107, ext. 201 (V/TTY); in SC)

ODPHP National Health Information Center
1(800) 336-4797 (V)

Office of Minority Health Resource Center
1(800) 444-6472 (V)

Zero to Three/National Center for Infants, Toddlers, and Families
1(800) 899-4301

LITERACY
Laubach Literacy
1(888) 528-2224

National Contact Hotline
1(800) 228-8813; 1(800) 552-9097

MEDICAL/HEALTH DISORDERS
American Association of Kidney Patients
1(800) 749-2257 (V)

American Brain Tumor Association
1(800) 886-2282

American Cancer Society
1(800) 227-2345

American Diabetes Association
1(800) 342-2383 (V)

American Heart Association
1(800) 242-8721

American Kidney Fund
1(800) 638-8299 (V)

American Liver Foundation
1(800) 223-0179 (V)

American Lung Association
1(800) 586-4872

Aplastic Anemia & MDS International Foundation
1(800) 747-2820

Asthma and Allergy Foundation of America
1(800) 727-8462

Chronic Fatigue and Immune Dysfunction Syndrome Association
1(800) 442-3437 (V)

Crohn and Colitis Foundation of America
1(800) 932-2423

Eating Disorders Awareness and Prevention
1(800) 931-2237

Family Voices: A National Coalition Speaking for Children with Special Health Care Needs
1(888) 835-5669

Federal Hill-Burton Free Hospital Care Program
1(800) 638-0742 (V)
1(800) 492-0359 (V; in MD)

Foundation for Ichthyosis and Related Skin Types
1(800) 545-3286

Leukemia and Lymphoma Society (formerly the Leukemia Society of America)
1(800) 955-4572 (V)

Lupus Foundation of America
1(800) 558-0121 (V)
1(800) 558-0231 (V; Spanish)

National Brain Tumor Foundation
1(800) 934-2873

National Heart, Lung, and Blood Institute
Information Center
1(800) 575-9355

National Lymphedema Network
1(800) 541-3259

Shriners Hospital for Crippled Children
1(800) 237-5055 (V)

Sickle Cell Disease Association of America
1(800) 421-8453 (V)

United Ostomy Association
1(800) 826-0826 (V)

Vestibular Disorders Association
1(800) 837-8428

MENTAL HEALTH
National Alliance for the Mentally Ill
1(800) 950-6264 (V)

National Mental Health Association
1(800) 969-6642 (V)
1(800) 433-5959 (TTY)

National Mental Health Consumer Self-Help
Clearinghouse
1(800) 553-4539

Research and Training Center on Family Support
and Children's Mental Health
1(800) 547-8887

NUTRITION
Beech-Nut Nutrition Hotline
1(800) 523-6633 (V)

Gerber Parents Resource Center
1(800) 443-7237 (V)

PHYSICAL DISABILITIES
Christopher Reeve Paralysis Foundation
1(800) 225-0292

Human Growth Foundation
(800) 451-6434 (V)

Muscular Dystrophy Association
1(800) 572-1717

National Library Services for the Blind and
Physically Handicapped
1(800) 424-8567
1(202) 707-0744 (TTY)

National Limb Loss Information Center
1(888) 267-5669

National Spinal Cord Injury Hotline
1(800) 526-3456 (V)

Pathways Awareness Foundation
1(800) 955-2445 (V)

RARE SYNDROMES
The Genetic Alliance
1(800) 336-4363 (V)

National Organization for Rare Disorders
1(800) 999-6673 (V/TTY)

RECREATION
Adventures in Movement for the
Handicapped, Inc.
1(800) 332-8210 (V)

Magic Foundation
1(800) 362-4423 (V)

North American Riding for the
Handicapped, Inc.
1(800) 369-7433 (V)

Sunshine Foundation
1(800) 767-1976 (V)

REHABILITATION
ABLEDATA
1(800) 227-0216 (V/TTY)

Childrens Resource Line
1(800) 638-8864 (V)

National Clearinghouse of Rehabilitation
Training Materials
1(800) 223-5219 (V/TTY)

RESPIRATORY DISORDERS
National Jewish Center for Immunology and Respiratory Medicine — LUNGLINE
1(800) 222-5864 (V)

National Heart, Lung, and Blood Institute Information Center
1(800) 575-9355

RESPITE CARE
Access to Respite Care and Help (ARCH) National Resource Center, National Respite Locator Service
1(800) 773-5433 (V)

RURAL
ERIC Clearinghouse on Rural Education and Small Schools
1(800) 624-9120 (V)

Rural Institute on Disabilities (Montana Univ. Affiliated Program)
1(800) 732-0323

SPECIFIC DISABILITIES
American Association on Mental Retardation
1(800) 424-3688 (outside D.C. area)
(202) 387-1968 (in D.C.)

Angelman Syndrome Foundation
1(800) 432-6435

Aplastic Anemia & MDS International Foundation
1(800) 747-2820

Autism Society of America
1(800) 3-AUTISM

Brain Injury Association
1(800) 444-6443 (V)

Children and Adults with Attention Deficit Disorder (CHADD)
1(800) 233-4050

Cleft Palate Foundation
1(800) 242-5338

Cooley's Anemia Foundation
1(800) 522-7222 (V)

Cornelia de Lange Syndrome Foundation
1(800) 223-8355 (V)
1(800) 753-2357 (V; in CT)

Crohn's and Colitis Foundation of America
1(800) 932-2423

Cystic Fibrosis Foundation
1(800) 344-4823 (V)

Epilepsy Foundation-National Office
1(800) 332-1000 (V)

Huntington's Disease Society of America
1(800) 345-4372

International Dyslexia Association (formerly the Orton Dyslexia Society)
1(800) 222-3123

International Rett Syndrome Association
1(800) 818-7388

Learning Disabilities Association
1(888) 300-6710

Lyme Disease Foundation
1(800) 886-5963

National Center for Learning Disabilities
1(888) 575-7373

National Center for Stutttering
1(800) 221-2483

National Down Syndrome Congress
1(800) 232-6372 (V)

National Down Syndrome Society
1(800) 221-4602 (V)

National Fragile X Foundation
1(800) 688-8765 (V)

National Lymphedema Network
1(800) 541-3259

National Multiple Sclerosis Society
1(800) 344-4867 (V)

National Neurofibromatosis Foundation
1(800) 323-7938

National Organization for Albinism and Hypopigmentation
1(800) 473-2310 (V)

National Organization on Fetal Alcohol Syndrome
1(800) 666-6327

National Reye's Syndrome Foundation
1(800) 233-7393 (V)

National Scoliosis Foundation
1(800) 673-6922

National Stuttering Association
1(800) 364-1677

National Tay-Sachs & Allied Diseases Association, Inc.
1(800) 906-8723

National Tuberous Sclerosis Association
1(800) 225-6872 (V)

Neurofibromatosis, Inc.
1(800) 942-6825

Osteogenesis Imperfecta Foundation
1(800) 981-2663

Prader-Willi Syndrome Association
1(800) 926-4797 (V)

Spina Bifida Association of America
1(800) 621-3141 (V)

Stuttering Foundation of America
1(800) 992-9392 (V)

Support Organization for Trisomy 17, 13, and Related Disorders
1(800) 716-7638

Sudden Infant Death Syndrome Alliance
1(800) 221-7437 (V)

Tourette Syndrome Association
1(800) 237-0717 (V)

Treacher Collins Foundation
1(800) 823-2055

United Cerebral Palsy Associations
1(800) 872-5827 (V/TTY)

United Leukodystrophy Foundation
1(800) 728-5483 (V)

United Scleroderma Foundation
1(800) 722-4673 (V)

SUPPLEMENTAL SECURITY INCOME (SSI)
Social Security Administration
1(800) 772-1213 (V)
1(800) 325-0778 (TTY)
1(800) 392-0812 (TTY; in MO)

TRAUMA
American Trauma Society
1(800) 556-7890 (V)
1(800) 735-2258 (TTY)

Brain Injury Association
1(800) 444-6443 (V)

National Spinal Cord Injury Association
1(800) 962-9629

August 2000

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National Information Center for Children and Youth with Disabilities

NICHCY

P.O. Box 1492
Washington, DC
20013-1492
E-Mail: nichcy@aed.org
Web: www.nichcy.org
1-800-695-0285 (Voice/TTY)

National Resources

CLEARINGHOUSES

Center on Positive Behavioral Interventions and Supports
1761 Alder Street, 1235 University of Oregon
Eugene, OR 97403
(541) 346-2505
E-mail: pbis@oregon.uoregon.edu
Web: www.pbis.org

Clearinghouse on Disability Information in the Office of Special Education and Rehabilitative Services
Room 3132, Switzer Building
330 C Street S.W., Washington, DC 20202-2524
(202) 205-8241 (Voice/TTY)

DB-LINK, National Information Clearinghouse on Children Who Are Deaf-Blind
345 N. Monmouth Avenue, Monmouth, OR 97361
(800) 438-9376 (Voice); (800) 854-7013 (TTY)
E-mail: dblink@tr.wou.edu
Web: www.tr.wou.edu/dblink/

ERIC Clearinghouse on Disabilities and Gifted Education
Council for Exceptional Children (CEC)
1110 N. Glebe Road, Suite 300, Arlington, VA 22201-5704
(800) 328-0272 (V/TTY)
E-mail: ericec@cec.sped.org
Web: http://ericec.org

HEATH Resource Center (National Clearinghouse on Postsecondary Education for Individuals with Disabilities)
One Dupont Circle, N.W., Suite 800
Washington, D.C. 20036-1193
(202) 939-9320 (Voice/TTY); (800) 544-3284
E-mail: heath@ace.nche.edu
Web: www.heath-resource-center.org

Laurent Clerc National Deaf Education Center and Clearinghouse
KDES PAS-6, 800 Florida Avenue, NE
Washington, DC 20002-3695
(202) 651-5051; (202) 651-5052 (TTY)
E-mail: Clearinghouse.Infotogo@gallaudet.edu
Web: http://clerccenter.gallaudet.edu

National Center on Secondary Education and Transition
Institute on Community Integration
University of Minnesota
6 Pattee Hall, 150 Pillsbury Drive S.E.
Minneapolis, MN 55455
(612) 624-2097
E-mail: ncset@icimail.coled.umn.edu
Web: http://ici.umn.edu/ncset

National Clearinghouse for Alcohol and Drug Information
P.O. Box 2345, Rockville, MD 20847-2345
(800) 729-6686; (301) 468-2345; (800) 487-4899 (TTY)
Publications available in Spanish
E-mail: info@health.org
Web: www.health.org

National Clearinghouse for Professions in Special Education
Council for Exceptional Children
1110 N. Glebe Road, Suite 300, Arlington, VA 22201-5704
(800) 641-7824; (703) 264-9480 (TTY)
E-mail: ncpse@cec.sped.org
Web: www.specialedcareers.org

National Diabetes Information Clearinghouse
One Information Way, Bethesda, MD 20892
(301) 654-3327
Publications available in Spanish
E-mail: ndic@info.niddk.nih.gov
Web: www.niddk.nih.gov/health/diabetes/ndic.htm

National Digestive Diseases Information Clearinghouse
Two Information Way, Bethesda, MD 20892
(301) 654-3327
Publications available in Spanish
E-mail: nddic@info.niddk.nih.gov
Web: www.niddk.nih.gov/health/digest/nddic.htm

National Health Information Center
P.O. Box 1133, Washington, DC 20013-1133
(800) 336-4797; (301) 565-4167
E-mail: nhicinfo@health.org
Web: nhic-nt.health.org/

National Heart, Lung, & Blood Institute Information Center
P.O. Box 30105, Bethesda, MD 20824-0105
(800) 575-9355; (301) 592-8573
E-mail: NHLBIinfo@rover.nhlbi.nih.gov
Web: www.nhlbi.nih.gov/

National Institute of Arthritis and Musculoskeletal and Skin Diseases Information Clearinghouse
1 AMS Circle, Bethesda, MD 20892-3675
(877) 226-4267; (301) 495-4484 (V); (301) 565-2966 (TTY)
E-mail: NAMSIC@mail.nih.gov
Web: www.nih.gov/niams
Spanish speaker on staff

National Institute on Deafness and Other Communication Disorders Clearinghouse
One Communication Avenue, Bethesda, MD 20892-3456
1-800-241-1044 (V); 1-800-241-1055 (TTY)
E-mail: nidcdinfo@nidcd.nih.gov
Web: www.nidcd.nih.gov

National Kidney and Urologic Diseases Information Clearinghouse
Three Information Way, Bethesda, MD 20892
(301) 654-3327
E-mail: nkudic@info.niddk.nih.gov
Web: www.niddk.nih.gov/health/kidney/nkudic.htm

National Lead Information Center
8601 Georgia Avenue, Suite 503
Silver Spring, MD 20910
(800) 424-5323
E-mail: hotline.lead@epa.gov
Web: www.epa.gov/lead/nlic.htm

National Maternal and Child Health Clearinghouse
2070 Chain Bridge Road, Suite 450
Vienna, VA 22182-2536
(888) 434-4624; (703) 821-8955
E-mail: nmchc@circsol.com
Web: www.nmchc.org
Publications available in Spanish; Spanish speaker on staff

National Organization for Rare Disorders (NORD)
P.O. Box 8923, New Fairfield, CT 06812-8923
(800) 999-6673; (203) 746-6518
(203) 746-6927 (TTY)
E-mail: orphan@rarediseases.org
Web: www.rarediseases.org

National Rehabilitation Information Center (NARIC)
1010 Wayne Avenue, Suite 800
Silver Spring, MD 20910-3319
(800) 346-2742; (301) 562-2403; (301) 495-5626 (TTY)
Web: www.naric.com

Research and Training Center on Family Support and Children's Mental Health, Portland State University
P.O. Box 751, Portland, OR 97207-0751
(800) 547-8887; (503) 725-4040; (503) 725-4165 (TTY)
E-mail: caplane@rri.pdx.edu
Web: www.rtc.pdx.edu/

Research and Training Center on Independent Living
University of Kansas
4089 Dole Building, Lawrence, KS 66045-2930
(785) 864-4095 (V/TTY)
E-mail: rtcil@ukans.edu
Web: www.lsi.ukans.edu/rtcil/rtcil.htm

ORGANIZATIONS

Alexander Graham Bell Association for the Deaf and Hard of Hearing
3417 Volta Place N.W., Washington, DC 20007
(202) 337-5220 (Voice); (202) 337-5221 (TTY)
E-mail: info@agbell.org
Web: www.agbell.org

Alliance for Technology Access
2175 East Francisco Boulevard, Suite L
San Rafael, CA 94901
(800) 455-7970; (415) 455-4575; (415) 455-0491 (TTY)
E-mail: atainfo@ataccess.org
Web: www.ataccess.org

American Anorexia Bulimia Association
165 West 46 Street #1108, New York, NY 10036
(212) 575-6200
E-mail: amanbu@aol.com
Web: www.aabainc.org

American Brain Tumor Association
2720 River Road, Des Moines, IA 60018
(847) 827-9910; (800) 886-2282 (Patient Services)
E-mail: info@abta.org
Web: www.abta.org

American Council of the Blind
1155 15th Street N.W., Suite 720, Washington, DC 20005
(800) 424-8666; (202) 467-5081
E-mail: ncrabb@erols.com
Web: www.acb.org

American Council on Rural Special Education (ACRES)
Kansas State University
2323 Anderson Avenue, Suite 226, Manhattan, KS 66502
(785) 532-2737
E-mail: acres@ksu.edu
Web: www.ksu.edu/acres

American Diabetes Association
1701 N. Beauregard Street, Alexandria, VA 22311
(800) 342-2383; (703) 549-1500
E-mail: customerservice@diabetes.org
Web: www.diabetes.org

American Foundation for the Blind (AFB)
11 Penn Plaza, Suite 300, New York, NY 10001
(800) 232-5463; (212) 502-7662 (TTY)
Publications available in Spanish
E-mail: afbinfo@afb.org
Web: www.afb.org

American Heart Association-National Center
7272 Greenville Avenue, Dallas, TX 75231
(800) 242-8721; (214) 373-6300
E-mail: inquire@amhrt.org
Web: www.americanheart.org

American Lung Association
1740 Broadway, New York, NY 10019
(800) 586-4872; (212) 315-8700
E-mail: info@lungusa.org
Web: www.lungusa.org/

American Occupational Therapy Association (AOTA)
4720 Montgomery Lane
P.O. Box 31220, Bethesda, MD 20824-1220
(301) 652-2682 (Voice)
Web: www.aota.org

American Physical Therapy Association (APTA)
1111 North Fairfax Street, Alexandria, VA 22314
(800) 999-2782; (703) 684-2782; (703) 683-6748 (TTY)
E-mail: practice@apta.org
Web: www.apta.org

American Society for Deaf Children
P.O. Box 3355, Gettysburg, PA 17325
(800) 942-2732; (717) 334-7922 (V/TTY)
E-mail: ASDC1@aol.com
Web: www.deafchildren.org

American Speech-Language-Hearing Association (ASHA)
10801 Rockville Pike, Rockville, MD 20852
(800) 498-2071 (V/TTY); (301) 571-0457 (TTY)
Publications available in Spanish; Spanish speaker on staff
E-mail: actioncenter@asha.org
Web: www.asha.org

American Therapeutic Recreation Association
1414 Prince Street, Suite 204, Alexandria, VA 22314
(703) 683-9420
E-mail: atra@atra-tr.org
Web: www.atra-tr.org

Angelman Syndrome Foundation
414 Plaza Drive, Suite 209
Westmont, IL 60559
(800) 432-6435; (630) 734-9267
E-mail: info@angelman.org
Web: www.angelman.org

Anxiety Disorders Association of America
11900 Parklawn Drive #100
Rockville, MD 20852-2624
(301) 231-9350
E-mail: AnxDis@adaa.org
Web: www.adaa.org

Aplastic Anemia & MDS International Foundation, Inc.
P. O. Box 613, Annapolis, MD 21404-0613
(800) 747-2820; (410) 867-0242
E-mail: aamdsoffice@aol.com
Web: www.aamds.org

The Arc (formerly the Association for Retarded Citizens)
1010 Wayne Avenue, Suite 650, Silver Spring, MD 20910
(301) 565-3842
E-mail: Info@thearc.org
Web: www.thearc.org

Asthma and Allergy Foundation of America
1233 20th Street, N.W., Suite 402
Washington, DC 20036
(800) 727-8462; (202) 466-7643
E-mail: info@aafa.org
Web: www.aafa.org/

Autism Society of America
7910 Woodmont Avenue, Suite 300
Bethesda, MD 20814-3015
(800) 328-8476; (301) 657-0881
Publications available in Spanish
Web: www.autism-society.org

Best Buddies International, Inc.
100 Southeast Second Street, Suite 1990
Miami, FL 33131
(305) 374-2233
E-mail: info@bestbuddies.org
Web: www.bestbuddies.org

Brain Injury Association
(formerly the National Head Injury Foundation)
105 North Alfred Street, Alexandria, VA 22314
(703) 236-6000; (800) 444-6443
Publications available in Spanish
E-mail: FamilyHelpline@biausa.org
Web: www.biausa.org

Center for Mental Health Services
Knowledge Exchange Network
P.O. Box 42490, Washington, DC 20015
(800) 789-2647; (301) 443-9006 (TTY)
Publications available in Spanish
E-mail: ken@mentalhealth.org
Web: www.mentalhealth.org

Center for Universal Design
North Carolina State University School of Design
Box 8613, Raleigh, NC 27695-8613
(800) 647-6777; (915) 515-3082 (V/TTY)
E-mail: cud@ncsu.edu
Web: www.design.ncsu.edu/cud

Childhood Apraxia of Speech Association of North America
123 Eisele Road, Cheswick, PA 15024
(412) 767-6589
E-mail: helpdesk@apraxia.org
Web: www.apraxia-kids.org

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD)
8181 Professional Place, Suite 201
Landover, MD 20785
(301) 306-7070
(800) 233-4050 (To request information packet)
E-mail: national@chadd.org
Web: www.chadd.org

Children's Craniofacial Association
P.O. Box 280297, Dallas, TX 75243-4522
(800) 535-3643; (972) 994-9902
E-mail: contactcca@ccakids.com
Web: www.ccakids.com

Children's Liver Alliance
3835 Richmond Avenue, Suite 190
Staten Island, NY 10312-3828
(718) 987-6200
E-mail: Livers4Kids@earthlink.net
Web: http://livertx.org

Chronic Fatigue and Immune Dysfunction Syndrome Association
P.O. Box 220398, Charlotte, NC 28222-0398
(800) 442-3437; (704) 365-9755
E-mail: info@cfids.org
Web: www.cfids.org

Closing the Gap, Inc.
(for information on computer technology in special education and rehabilitation)
P.O. Box 68, 526 Main Street, Henderson, MN 56044
(507) 248-3294
Web: www.closingthegap.com

Council for Exceptional Children (CEC)
1110 N. Glebe Road, Suite 300, Arlington, VA 22201-5704
(703) 620-3660 (Voice); (703) 264-9446 (TTY)
E-mail: cec@cec.sped.org
Web: www.cec.sped.org/

Craniofacial Foundation of America
975 East Third Street, Chattanooga, TN 37403
(800) 418-3223; (423) 778-9192
Web: www.erlanger.org/cranio/found1.html

Disability Statistics Rehabilitation, Research and Training Center
3333 California St., Room 340
University of California at San Francisco
San Francisco, CA 94118
(415) 502-5210 (Voice); (415) 502-5217 (TTY)
E-mail: distats@itsa.ucsf.edu
Web: dsc.ucsf.edu

Easter Seals—National Office
(formerly the National Easter Seal Society)
230 West Monroe Street, Suite 1800
Chicago, IL 60606
(800) 221-6827; (312) 726-6200; (312) 726-4258 (TTY)
E-Mail: info@easter-seals.org
Web: www.easter-seals.org

Eating Disorders Awareness and Prevention, Inc. (EDAP)
603 Stewart Street, Suite 803
Seattle, WA 98101
(800) 931-2237; (206) 382-3587
E-mail: info@edap.org
Web: www.edap.org

Epilepsy Foundation—National Office
4351 Garden City Drive, 5th Floor
Landover, MD 20785-4941
(800) 332-1000; (301) 459-3700
Publications available in Spanish; Spanish speaker on staff
E-mail: postmaster@efa.org
Web: www.efa.org

FACES: The National Craniofacial Association
P.O. Box 11082, Chattanooga, TN 37401
(800) 332-2372; (423) 266-1632
E-mail: faces@faces-cranio.org
Web: www.faces-cranio.org

Family Resource Center on Disabilities
20 East Jackson Boulevard, Room 900
Chicago, IL 60604
(800) 952-4199 (Voice/TTY; toll-free in IL only)
(312) 939-3513 (Voice); (312) 939-3519 (TTY)

Family Village
(a global community of disability-related resources)
Waisman Center, University of Wisconsin-Madison
1500 Highland Avenue, Madison, WI 53705-2280
Web: www.familyvillage.wisc.edu/

Family Voices (a national coalition speaking for children with special health care needs)
3411 Candelaria NE, Suite M, Albuquerque, NM 87107
(888) 835-5669 (Tollfree)
E-mail: kidshealth@familyvoices.org
Web: www.familyvoices.org

Father's Network
16120 N.E. 8th Street
Bellevue, WA 98008-3937
(425) 747-4004, ext. 218
E-mail: jmay@fathersnetwork.org
Web: www.fathersnetwork.org

Federation of Families for Children's Mental Health
1101 King Street, Suite 420, Alexandria, VA 22314
(703) 684-7710
Publications available in Spanish
E-mail: ffcmh@ffcmh.org
Web: www.ffcmh.org

Foundation for Ichthyosis and Related Skin Types
650 N. Cannon Avenue, Suite 17
Lansdale, PA 19446
(215) 631-1411
E-mail: info@scalyskin.org
Web: www.scalyskin.org

The Genetic Alliance (formerly the Alliance of Genetic Support Groups)
4301 Connecticut Avenue N.W., Suite 404
Washington, DC 20008
(800) 336-4363; (202) 966-5557
E-mail: info@geneticalliance.org
Web: www.geneticalliance.org

Head Start Bureau
Administration on Children, Youth and Families
U.S. Department of Health & Human Services
P.O. Box 1182, Washington, DC 20013
Web: www.acf.dhhs.gov/programs/hsb/

Huntington's Disease Society of America
158 West 29th Street, 7th Floor
New York, NY 10001-5300
(800) 345-4372; (212) 242-1968
E-mail: hdsainfo@hdsa.org
Web: www.hdsa.org

Hydrocephalus Association
870 Market Street #705, San Francisco, CA 94102
(415) 732-7040
E-mail: hydroassoc@aol.com
Web: www.hydroassoc.org

Independent Living Research Utilization Project
The Institute for Rehabilitation and Research
2323 South Sheppard, Suite 1000, Houston, TX 77019
(713) 520-0232 (Voice); (713) 520-5136 (TTY)
E-mail: ilru@ilru.org
Web: www.ilru.org

International Dyslexia Association
(formerly the Orton Dyslexia Society)
Chester Building #382
8600 LaSalle Road, Baltimore, MD 21286-2044
(800) 222-3123; (410) 296-0232
E-mail: info@interdys.org
Web: www.interdys.org

International Resource Center for Down Syndrome
Keith Building
1621 Euclid Avenue, Suite 514, Cleveland, OH 44115
(216) 621-5858; (800) 899-3039 (toll-free in OH only)
E-mail: hf854@cleveland.freenet.edu

International Rett Syndrome Association
9121 Piscataway Rd., Suite 2B, Clinton, MD 20735-2561
(800) 818-7388; (301) 856-3334
E-mail: irsa@rettsyndrome.org
Web: www.rettsyndrome.org

Job Accommodation Network (JAN)
West Virginia University
918 Chestnut Ridge Road, Suite 1
P.O. Box 6080, Morgantown, WV 26506-6080
(800) 526-7234 (Voice/TTY)
(800) 232-9675 (Voice/TTY, information on the ADA)
E-mail: jan@.icdi.wvu.edu
Web: www.jan.wvu.edu

Learning Disabilities Association of America (LDA)
4156 Library Road, Pittsburgh, PA 15234
(888) 300-6710; (412) 341-1515; (412) 341-8077
Publications available in Spanish
E-mail: ldanatl@usaor.net
Web: www.ldanatl.org

Leukemia & Lymphoma Society (formerly Leukemia Society of America)
600 Third Avenue, New York, NY 10016
(800) 955-4572; (212) 573-8484
E-mail: infocenter@leukemia-lymphoma.org
Web: www.leukemia-lymphoma.org

Little People of America—National Headquarters
P.O. Box 745, Lubbock, TX 79408
(888) 572-2001
Spanish speaker on staff
E-mail: LPADataBase@juno.com
Web: www.lpaonline.org

March of Dimes Birth Defects Foundation
1275 Mamaroneck Avenue, White Plains, NY 10605
(914) 428-7100; (888) 663-4637
Publications available in Spanish; Spanish speaker on staff
E-mail: resourcecenter@modimes.org
Web: www.modimes.org

Muscular Dystrophy Association (MDA)
3300 East Sunrise Drive, Tucson, AZ 85718
(800) 572-1717; (520) 529-2000
Publications available in Spanish; Spanish speaker on staff
E-mail: mda@mdausa.org
Web: www.mdausa.org

National Alliance for the Mentally Ill (NAMI)
Colonial Place Three, 2107 Wilson Blvd, Suite 300
Arlington, VA 22201-3042
(800) 950-6264; (703) 524-7600; (703) 516-7991 (TTY)
Publications available in Spanish; Spanish speaker on staff
E-mail: helpline@nami.org
Web: www.nami.org

National Association of the Deaf
814 Thayer Avenue, Suite 250, Silver Spring, MD 20910
(301) 587-1788; (301) 587-1789 (TTY)
E-mail: nadinfo@nad.org
Web: www.nad.org

National Association of Private Schools for Exceptional Children (NAPSEC)
1522 K Street N.W., Suite 1032, Washington, DC 20005
(202) 408-3338
E-mail: napsec@aol.com
Web: www.napsec.com

National Association of Protection and Advocacy Systems (NAPAS)
900 Second Street N.E., Suite 211, Washington, DC 20002
(202) 408-9514 (Voice); (202) 408-9521 (TTY)
E-mail: napas@earthlink.net
Web: www.protectionandadvocacy.com/

National Ataxia Foundation
2600 Fernbrook Lane, Suite 119, Minneapolis,, MN 55447
(612) 553-0020
E-mail: naf@mr.net
Web: www.ataxia.org

National Attention Deficit Disorder Association
1788 Second Street, Suite 200, Highland Park, IL 60035
(847) 432-2332 (to leave a message)
E-mail: mail@add.org
Web: www.add.org

National Brain Tumor Foundation
414 13th Street, Suite 700, Oakland, CA 94612
(800) 934-2873; (510) 839-9777
E-mail: nbtf@braintumor.org
Web: www.braintumor.org

National Center for Learning Disabilities (NCLD)
381 Park Avenue South, Suite 1401, New York, NY 10016
(888) 575-7373; (212) 545-7510
Web: www.ncld.org

National Chronic Fatigue Syndrome and Fibromyalgia Association (NCFSFA)
P.O. Box 18426, Kansas City, MO 64133
(816) 313-2000
E-mail: NCFSFA@aol.com

National Council on Independent Living
1916 Wilson Boulevard, Suite 209
Arlington, VA 22201
(703) 525-3406; (703) 525-4153 (TTY)
E-mail: ncil@ncil.org
Web: www.ncil.org

National Down Syndrome Congress
7000 Peachtree-Dunwoody Road N.E., Lake Ridge 400 Office Building 5, Suite 100, Atlanta, GA 30328
(800) 232-6372; (770) 604-9500
Parent packet available in Spanish; Spanish speaker on staff
E-mail: NDSCcenter@aol.com
Web: www.ndsccenter.org

National Down Syndrome Society
666 Broadway, 8th Floor, New York, NY 10012-2317
(800) 221-4602; (212) 460-9330
E-mail: info@ndss.org
Web: ndss.org

National Federation of the Blind
1800 Johnson Street, Baltimore, MD 21230
(410) 659-9314
E-mail: nfb@nfb.org
Web: www.nfb.org

National Fragile X Foundation
1441 York Street, Suite 303, Denver, CO 80206
(800) 688-8765; (303) 333-6155
E-mail: natlfx@sprintmail.com
Web: nfxf.org

National Library Service for the Blind & Physically Handicapped, The Library of Congress
1291 Taylor Street N.W., Washington, DC 20542
(800) 424-8567; (202) 707-5100; (202) 707-0744 (TTY)
Publications available in Spanish
E-Mail: nls@loc.gov
Web: www.loc.gov/nls

National Mental Health Association
1021 Prince Street, Alexandria, VA 22314-2971
(800) 969-6642; (703) 684-7722; (800) 433-5959 (TTY)
Publications available in Spanish
E-mail: nmhainfo@aol.com
Web: www.nmha.org

National Multiple Sclerosis Society
733 Third Avenue, New York, NY 10017
(800) 344-4867; (212) 986-3240
E-mail: info@nmss.org
Web: www.nmss.org

National Neurofibromatosis Foundation
95 Pine Street, 16th Floor, New York, NY 10005
(800) 323-7938; (212) 344-6633
E-Mail: nnff@nf.org
Web: www.nf.org

National Organization for Albinism and Hypopigmentation
P.O. Box 959, East Hampstead, NH 03826-0959
(800) 473-2310; (603) 887-2310
Publications available in Spanish
E-mail: info@albinism.org
Web: www.albinism.org

National Organization on Fetal Alcohol Syndrome (NOFAS)
216 G Street N.E., Washington, DC 20002
(800) 666-6327; (202) 785-4585
E-mail: nofas@erols.com
Web: www.nofas.org

National Parent Network on Disabilities
1130 17th St. N.W., Suite 400, Washington, DC 20036
(202) 463-2299 (V/TTY)
E-Mail: npnd@mindspring.com
Web: www.npnd.org

National Patient Air Transport Hotline
P.O. Box 1940, Manassas, VA 20108-0804
(800) 296-1217
E-Mail: npathmsg@aol.com
Web: www.npath.org

National Reyes Syndrome Foundation
P.O. Box 829, Bryan, OH 43506
(800) 233-7393; (419) 636-2679
E-mail: nrsf@reyessyndrome.org
Web: www.reyessyndrome.org

National Resource Center for Paraprofessionals in Education and Related Services
6526 Old Main Hill, Utah State University
Logan, UT 84322-6526
(435) 797-7272
E-mail: info@nrcpara.org
Web: www.nrcpara.org

National Scoliosis Foundation
5 Cabot Place, Stoughton, MA 02072
(800) 673-6922; (781) 341-6333
E-mail: scoliosis@aol.com

National Sleep Foundation
1522 K Street, N.W., Suite 500, Washington, DC 20005
(202) 347-3471
E-mail: nsf@sleepfoundation.org
Web: www.sleepfoundation.org

National Spinal Cord Injury Association
8300 Colesville Road, Suite 551, Silver Spring, MD 20910
(800) 962-9629; (301) 588-6959
E-mail: nscia2@aol.com
Web: www.spinalcord.org

National Stuttering Association
5100 E. La Palma Avenue, Suite 208
Anaheim Hills, CA 92807
(800) 364-1677; (714) 693-7480
E-mail: nsastutter@aol.com
Web: www.nsastutter.org

National Tuberous Sclerosis Association
8181 Professional Place, Suite 110
Landover, MD 20785-2226
(800) 225-6872; (301) 459-9888
E-mail: ntsa@ntsa.org
Web: www.ntsa.org

Neurofibromatosis, Inc.
8855 Annapolis Road, Suite 110, Lanham, MD 20706-2924
(800) 942-6825; (301) 577-8984
E-mail: NFInc1@aol.com
Web: www.nfinc.org

Obsessive Compulsive Foundation, Inc.
337 Notch Hill Road, North Branford, CT 06471
(203) 315-2190
E-mail: info@ocfoundation.org
Web: www.ocfoundation.org

Osteogenesis Imperfecta Foundation
804 Diamond Ave., Suite 210, Gaithersburg, MD 20878
(800) 981-BONE; (301) 947-0083
E-mail: bonelink@aol.com
Web: www.oif.org

Parents Helping Parents: The Parent-Directed Family Resource Center for Children with Special Needs
3041 Olcott Street, Santa Clara, CA 95054
(408) 727-5775
Publications available in Spanish; Spanish speaker on staff
E-mail: info@php.com
Web: www.php.com

Pathways Awareness Foundation
123 North Wacker Drive, Chicago, IL 60606
(800) 955-2445; (312) 236-7411 (TTY)
Brochure and video available in Spanish
Web: www.pathwaysawareness.org

Prader-Will[illegible]drome Association
5700 Midnight Pass Road, Suite 6
Sarasota, FL 34242
(800) 926-4797; (941) 312-0400
E-mail: pwsausa@aol.com
Web: www.pwsausa.org

Recording for the Blind and Dyslexic
The Anne T. Macdonald Center
20 Roszel Road, Princeton, NJ 08540
(800) 221-4792; (609) 452-0606
E-mail: custserv@rfbd.org
Web: www.rfbd.org

Registry of Interpreters for the Deaf
8630 Fenton Street, Suite 324, Silver Spring, MD 20910
(301) 608-0050 (V/TTY)
E-mail: info@rid.org
Web: www.rid.org

RESNA (Rehabilitation Engineering and Assistive Technology Society of North America)
1700 N. Moore Street, Suite 1540
Arlington, VA 22209-1903
(703) 524-6686 (Voice); (703) 524-6639 (TTY)
E-mail: natloffice@resna.org
Web: www.resna.org

Schwab Foundation for Learning
1650 S. Amphlett Blvd., Suite 300, San Mateo, CA 94402
E-mail: webmaster@schwablearning.org
Web: www.schwablearning.org

Special Olympics International
1325 G Street N.W., Suite 500, Washington, DC 20005
(202) 628-3630
Publications available in Spanish and French
Spanish-French speaker on staff
E-mail: specialolympics@msn.com
Web: www.specialolympics.org/

Spina Bifida Association of America
4590 MacArthur Boulevard, N.W., Suite 250
Washington, DC 20007-4226
(800) 621-3141; (202) 944-3285
Publications available in Spanish
E-mail: sbaa@sbaa.org
Web: www.sbaa.org

Stuttering Foundation of America
3100 Walnut Grove Road #603,
P.O. Box 11749, Memphis, TN 38111
(800) 992-9392
E-mail: stuttersfa@aol.com
Web: www.stuttersfa.org

TASH (formerly the Association for Persons with Severe Handicaps)
29 W. Susquehanna Ave., Suite 210, Baltimore, MD 21204
(410) 828-8274 (Voice); (410) 828-1306 (TTY)
E-mail: info@tash.org
Web: www.tash.org

Technical Assistance Alliance for Parent Centers (the Alliance), PACER Center
8161 Normandale Blvd., Minneapolis, MN 55437-1044
(888) 248-0822; (952) 838-9000; (952) 838-0190 (TTY)
Spanish speaker on staff
E-mail: alliance@taalliance.org
Web: www.taalliance.org

Tourette Syndrome Association
42-40 Bell Boulevard, Bayside, NY 11361
(800) 237-0717; (718) 224-2999
E-mail: ts@tsa-usa.org
Web: www.tsa-usa.org

Trace Research & Development Center
University of Wisconsin-Madison
5901 Research Park Boulevard, Madison, WI 53719-1252
(608) 262-6966; (608) 262-5408 (TTY)
E-mail: web@trace.wisc.edu
Web: trace.wisc.edu/

United Cerebral Palsy Associations, Inc.
1660 L Street, N.W., Suite 700, Washington, DC 20036
(202) 776-0406; (800) 872-5827; (202) 973-7197 (TTY)
Publications available in Spanish
E-Mail: ucpnatl@ucpa.org
Web: www.ucpa.org

Vestibular Disorders Association
P.O. Box 4467, Portland, OR 97208-4467
(800) 837-8428; (503) 229-7705
E-mail: veda@vestibular.org
Web: www.vestibular.org

Williams Syndrome Association, Inc.
P.O. Box 297, Clawson, MI 48017-0297
(248) 541-3630
E-mail: wsaoffice@aol.com
Web: www.williams-syndrome.org

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ONLINE RESOURCES

Acoustic Neuroma Association
URL: http://ANAusa.org/
e-mail: ANAusa@aol.com

American Cancer Society
URL: http://www.cancer.org/

Association of Pediatric Oncology Nurses (APON)
URL: http://www.apon.org/
e-mail: apon@amctec.com

Cancer Net (National Cancer Inst.)
URL: http://cancernet.nci.nih.gov/

Candlelighters Childhood Cancer Family Alliance
URL: http://www.candle.org/
e-mail: candle@candle.org

Council for Exceptional Children (CEC)
URL: http://www.cec.sped.org
e-mail: service@cec.sped.org

Early Childhood Research Institute on Service Utilization ECRI:SU
URL: http://www.unc.edu/depts/ecri

Federation of Families for Children's Mental Health (FFCMH)
URL: http://www.ffcmh.org
e-mail: ffcmh@crosslink.net

Human Growth Foundation
URL: http://www.medhelp.org/web/hgf.htm
e-mail: hgfound@erols.com

LD (Learning Disabilities) On-Line
URL: http://www.LDonline.org
e-mail: LDonLine@weta.com

Leukemia Society of America
URL: http://www.leukemia.org/
e-mail: pockf@leukemia.org

LRP Publications; Special Education Law Publications
URL: http://www.LRP.com/ed
e-mail: custserve@LRP.com

Make A Wish Foundation
URL: http://www.wish.org
e-mail: MAWFA@wish.org

National Clearinghouse for Professions In Special Education (NCPSE)
URL: http://www.special-ed-careers.org

National Council on Disability
(NCD is an independent federal agency working with the President and the Congress to increase the independence and empower-ment of all Americans with disabilities. The site has news of issues affecting people with disabilities including IDEA.) (202) 272-2004.
URL: http://www.ncd.gov
e-mail: mquigley@ncd.gov

National Information Clearinghouse on Children Who Are Deaf-Blind (DB-LINK)
URL: http://www.tr.wosc.osshe.edu/dblink
e-mail: dblink@wou.edu

National Marrow Donor Program
URL: http://www.marrow.org/
e-mail: webmaster@nmdp.org

National Mental Health Services/ Knowledge Exchange Network (KEN)
(800) 790-2647
URL: http://www.mentalhealth.org
e-mail: ken@mentalhealth.org

National Organization for Persons with Albinism & Hypopigmentation (NOAH)
URL: http://www.albinism.org
e-mail: webmaster@albinism.org

National Organization for Rare Disorders (NORD)
URL: http://www.rarediseases.org
e-mail: orphan@rarediseases.org

National Respite Network
(formerly ARCH Network)
URL: http://chtop.com/locator.htm
e-mail: HN4735@connectinc.com

National Technical Assistance Consortium for Children and Young Adults
Who Are Deaf-Blind (NTAC)
URL: http://www.tr.wosc.osshe.edu/ntac
e-mail: ntac@wou.edu

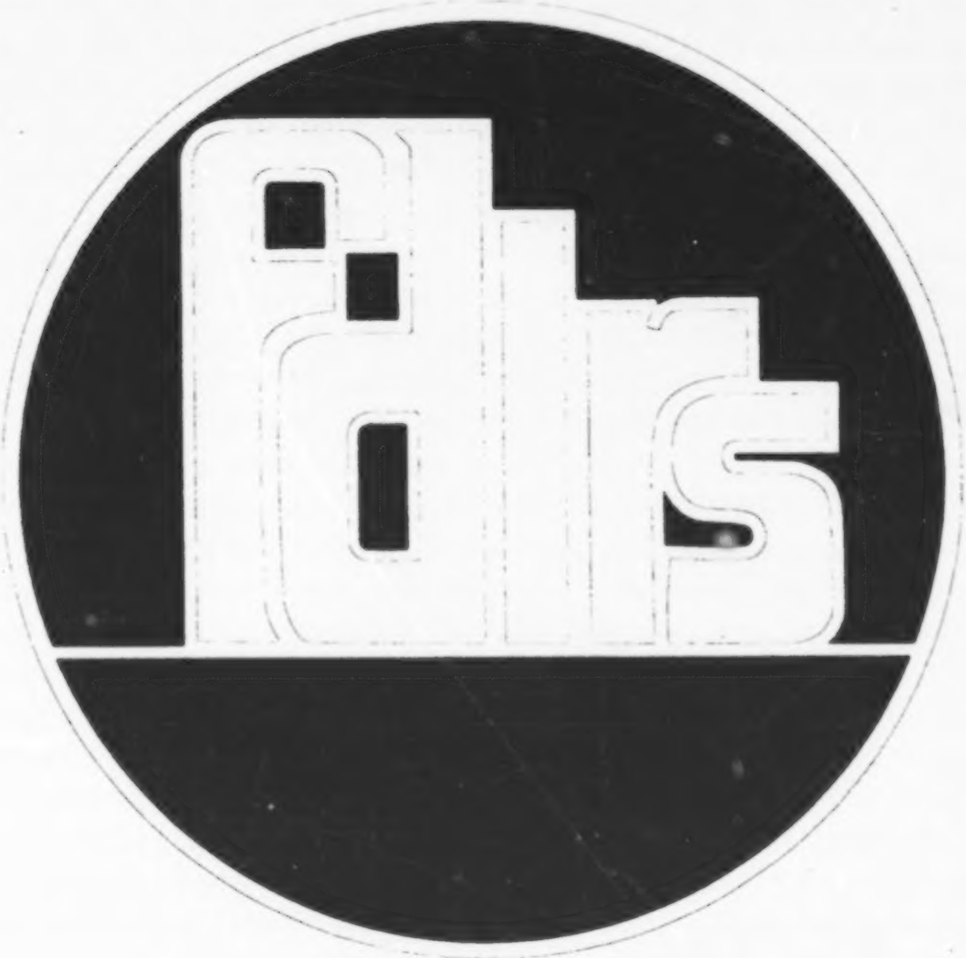
Pike Institute On Law and Disability
URL: http://www.bu.edu/law/pike/
e-mail: pikeinst@bu.edu

Project Tech-Link
(Linking educators and parents to transition best practices through computer technology)
URL: http://www.vcu.edu/rrtcweb/techlink
e-mail: kinge@atlas.vcu.edu

Sickle Cell Anemia
URL: http://wellweb.com/INDEX/QSICKLE.HTM
e-mail: wellness@wellweb.com

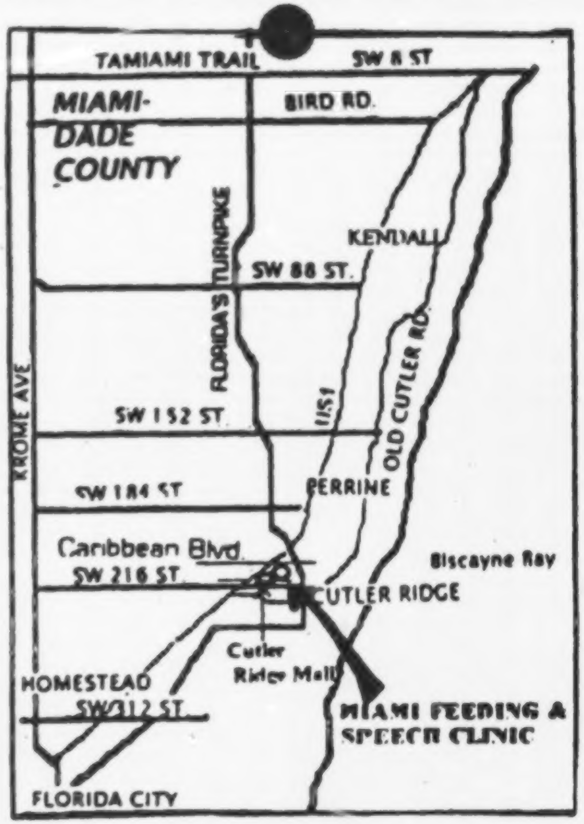
TASH
(An international association of people with disabilities, their families, advocates and professionals fighting for a society in which inclusion of all people in all aspects of society is the norm.
(410) 828-8274.
URL: http://www.tash.org
e-mail: mweiss@tash.org

Turner's Syndrome Society of the US
URL: http://www.turner-syndrome-us.org
e-mail: webmaster@turner-syndrome-us.org



Clara Z. Dawson, M.S., CCC-SLP
Ms. Dawson received her master's degree in 1987 from Texas Christian University, Fort Worth. She is co-director and co-owner of the Miami Feeding & Speech Clinic, Inc. She has extensive experience treating children and adults in a wide variety of therapy settings, including hospitals, skilled nursing facilities, home health, birth to three programs, private clinics, regular and special education public schools. She has developed over the years specialties in the areas of pediatric dysphagia and language stimulation in small children. She also has developed a hands-on, multisensory language stimulation approach called, "Posters & Gadgets", tailored for the pre-school population. Ms. Dawson is a certified member of ASHA and holds a Florida State License.

Digna M. Montoya, M.S., CCC-SLP
Ms. Montoya received her bachelor's and master's degree from the University of Puerto Rico/Medical Science Campus She is co-director and co-owner of the Miami Feeding & Speech Clinic, Inc. She has over 18 years of experience working with clients of all ages in a variety of settings, including schools, birth to three programs, home health, skilled nursing facilities, hospitals, private practice, and pediatric clinics for medically fragile/tracheostomized infants and small children. Ms. Montoya specializes in the areas of oral motor disorders, pediatric dysphagia, autism, PDD, ADD, and learning disabilities. She has made significant contributions to the development of " Posters & Gadgets" and has designed our pediatric swallowing program. Mrs. Montoya is a certified member of ASHA and holds a Florida State License.


TAMIAMI TRAIL
SW 8 ST
MIAMI-DADE COUNTY
BIRD RD.
KENDALL
SW 88 ST.
FLORIDA'S TURNPIKE
KROME AVE
SW 152 ST
US1
OLD CUTLER RD.
SW 184 ST
PERRINE
Caribbean Blvd.
SW 216 ST
Biscayne Bay
CUTLER RIDGE
Cutler Ridge Mall
HOMESTEAD
SW 312 ST
MIAMI FEEDING & SPEECH CLINIC
FLORIDA CITY

Miami Feeding & Speech Clinic, Inc

Open from 9 to 5 • After hours by appointment
10700 Caribbean Blvd.
Suite 312A
Miami, Fl 33189
Phone & Fax (786) 242-0886

Cash • Personal checks • Credit Cards •
Medicaid Accepted

Miami Feeding & Speech Clinic

Miami Feeding & Speech Clinic,Inc.

Quality therapy that works...

- **Early Intervention Language Program**
- **Pediatric Feeding & Swallowing Program**
- **Phonological / Articulation Disorders**
- **Aphasia, Dysarthria, Apraxia and other Neurological Disorders**
- **Parent/teacher/caretaker education and training**
- **Consultative services and workshops**
- **Bi-lingual Staff**

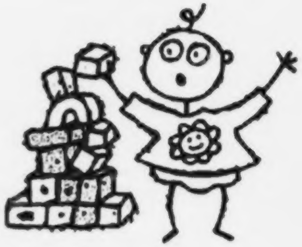
WHO ARE WE AND WHAT DO WE DO?

At the Miami Feeding &Speech Clinic, we provide speech/language assessment and intervention to infants, children and adults with special needs. Our early intervention services include a pediatric dysphagia program for children with feeding and swallowing disorders and our very own multisensory language stimulation program (Posters & Gadgets) for pre-school (PK) children. We also offer computer assisted speech and language therapy for the post CVA adult, traumatic brain injury and Parkinson's clients.

At our clinic, you will find a team of professionals who believe that to make therapy really work we need to provide the best quality, most effective and state-of-the-art clinical practice, as well as, educate and train parents, teachers, family members and caretakers.

WHAT KIND OF LANGUAGE PROGRAM DO WE HAVE?

Our language stimulation program is based on Posters & Gadgets which is a multisensory, integrated, structured and systematic language stimulation program designed for pre-school children to increase their receptive and expressive language skills. Posters & Gadgets derives its name from the use of blank environmental sceneries, a language stimuli presenter ,manipulative objects and pictures in a hands on approach. This program is ideal for clinicians working with children in small therapy groups and for school teachers during "circle time" activities. This program integrates aspects of various approaches such as Melodic Therapy, Picture Exchange Communication System, High Scope Program, and Montessori Program,among others, to facilitate learning. In particular, we have found that children with disabilities such as autism, down syndrome and attention deficits, respond very well to this approach because it helps them focus on one stimulus item at a time while providing structure. We have found that when adapting classroom toys and using the tools and materials created for this program, it is possible to effectively teach the majority of the skills and basic concepts in the PK curriculum to children with or without disabilities.



WHO WILL BENEFIT FROM THE PEDIATRIC FEEDING/SWALLOWING PROGRAM?

Our pediatric feeding/swallowing program is designed to provide assessment and/or intervention to children with feeding and swallowing disorders. Certain groups of children, such as those with medically related conditions (cerebral palsy, prematurity, failure to thrive,asphyxia, etc.), run a high risk for feeding and swallowing disorders. Our feeding/swallowing program provides therapy for children who:

- are at risk of aspiration
- are presenting symptoms of aspiration
- are transitioning from receiving nutrition via peg-tube to oral feeding
- have not reached their optimum diet due to the presence of abnormal/immature oral-motor patterns and movements

We have access to resources in the community to be able to provide our clients with a multidisciplinary team to achieve a coordinated approach to assessment and treatment. These resources include specialists in pediatric videofluoroscopy studies, pediatric gastroenterologists, dietitians, and occupational and/or physical therapists.

SCHOOL SCREENING PROGRAM

The Hearing and Speech Center of Florida takes pride in its comprehensive screening program, the first of its kind in South Florida, which has evolved into a complete battery utilizing the latest techniques and technology. A team of Speech-Language Pathologists, Audiologists, and Psychologists provide screenings in the following areas:

Speech:
Articulation of sounds and words in sentences.

Language:
Understanding of language concepts and use of correct grammatical patterns.

Hearing:
Pure-tone assessment of hearing acuity. Tympanometry assessment of middle ear function.

Vision:
Assessment of visual acuity.

Psycho-Educational:
Pre-academic skills screening is available on an individual basis.

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Therapy is available at our Centers or at your school. Presentations and in-services for parents and teachers on speech and language development and possible problems are offered at schools. In addition, medical and educational follow-ups are facilitated rapidly due to our extensive networking in the community.

Early detection of a problem can prevent delays in a child's normal development. Speech, language and vision are the foundation for all future learning. For further information, please call our Center at 305.446.5597.

OTHER HEARING AND SPEECH CENTER SERVICES:

Complete Speech and Language Assessment

◆

Audiological Testing

◆

Hearing Aids & Assistive Listening Devices

◆

Lipreading Classes

◆

School and Hospital Screenings

◆

Occupational Therapy

◆

Accent and Dialect Reduction

◆

Public Speaking

HEARING AND SPEECH CENTER OF FLORIDA, INC.
2511 Ponce de Leon Blvd., Suite 203
Coral Gables, Florida 33134-6812
Telephone: 305.446.5597 VOICE/TDD
Fax: 305.448.0235 Email: HSCF@aol.com

Satellite South Dade Office:
27501 S. Dixie Highway, Suite 403
Naranja, Florida 33032

UNITED WAY

SCREENING
SPEECH
Language
Vision
HEARING
LEARNING
PREV
Iden
Referral
PARENT EDUCATION
Speech
Language
Vision
HEARING
LEARNING
PREVENTION
Identification
Referral
Speech
Language
Vision
HEARING
LEARNING

SCREENING TO IDENTIFY POSSIB
SPEECH/LANGUAGE, HEARING,
VISION OR LEARNING PROBLEMS

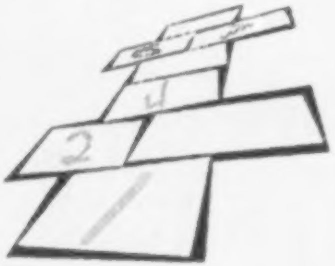
FDLRS-South
5555 S.W. 93 Avenue,
Miami, FL 33165
(305) 274-3501
Fax: (305) 598-7752

FDLRS-South Internet:
http://members.icanect.net/~fdlrs

How can I use FDLRS-SOUTH services?

The FDLRS-South system of support services is available to special and general education administrative, instructional and support personnel, universities, community agencies, private schools, parents and others involved in the education of exceptional students.

Contact:
FDLRS-South at (305) 274-3501 for additional information.
Take advantage of the services and materials available for you and the exceptional children you care for and serve.



FDLRS-South is one of 19 Associate Centers in Florida. The Florida Diagnostic and Learning Resources System (FDLRS) is funded through IDEA, Part B, Preschool, and State General Revenue Funds to provide support services for Florida's exceptional student education (ESE) programs.

MIAMI-DADE COUNTY
PUBLIC SCHOOLS (M-DCPS)
1450 N.E. 2 Avenue, Miami, FL 33132

Roger C. Cuevas
Superintendent of Schools

Joseph H. Mathos
Deputy Superintendent for Education

Ronald K. Felton
Assistant Superintendent
Office of Exceptional Student Education (ESE) and Psychological Services

Alina C. Diaz, J.D.
Instructional Supervisor
FDLRS-South
(305) 274-3501. Fax (305) 598-7752
http://members.icanect.net/~fdlrs

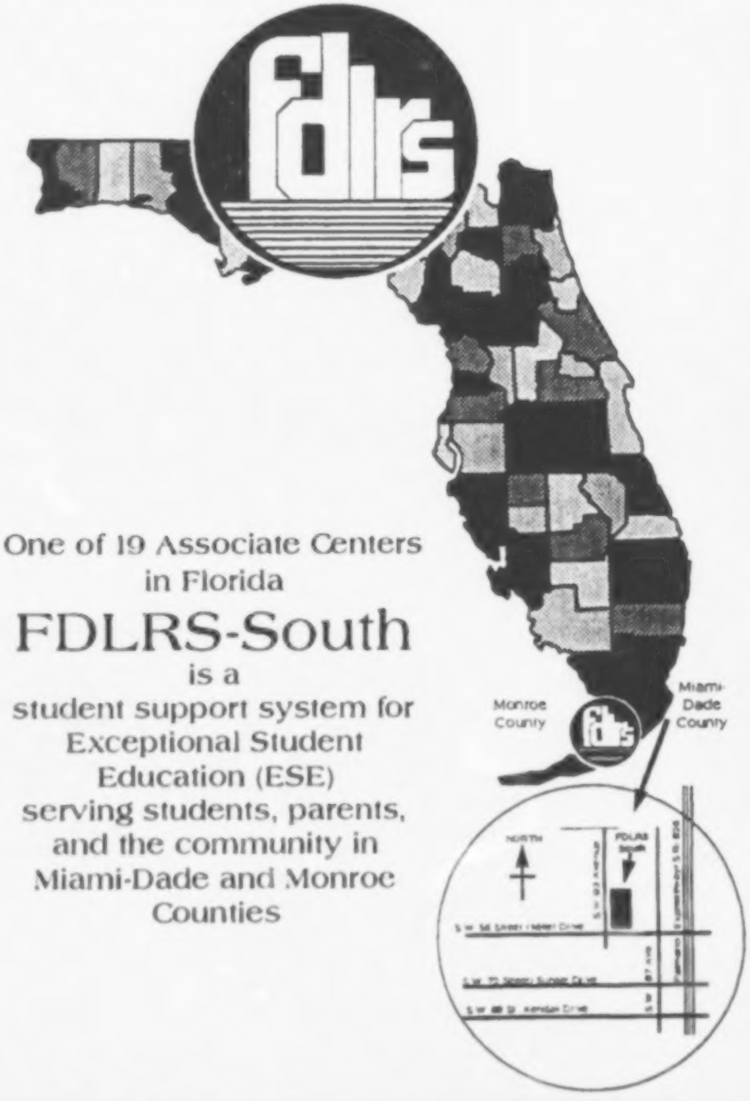
MONROE COUNTY
PUBLIC SCHOOLS
Michael Lannon
Superintendent of Schools

Douglas E. Sayre
Exceptional Student Education Director

Linda Welsh
FDLRS South CHILD FIND Specialist
1400 United Street, Key West, FL 33040
(305) 293-1646 Fax (305) 293-1485

A product of FDLRS South Graphics
Designed by Michelle Dresens
Rev. 7/20/99

The Florida Diagnostic and Learning Resources System-South



One of 19 Associate Centers
in Florida

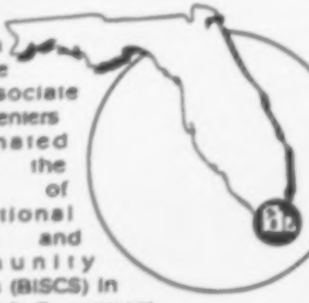
FDLRS-South

is a
student support system for
Exceptional Student
Education (ESE)
serving students, parents,
and the community in
Miami-Dade and Monroe
Counties

Office hours: 8 a.m. – 4:30 p.m.
Open 12 months. 5555 S.W. 93 Avenue, Miami, FL 33165

WHAT IS FDLRS-SOUTH?

The Florida Diagnostic and Learning Resources System-South, operating through the Miami-Dade County Public Schools, Office of Exceptional Student Education and Psychological Services is a special education support system for educators, parents, and professionals who work with exceptional children.



Within Florida there are 19 Associate FDLRS Centers coordinated through the Bureau of Instructional Support and Community Services (BISCS) in the Florida Department of Education (FDOE).

WHAT SERVICES DOES FDLRS-SOUTH PROVIDE?

I. CHILD-FIND

FDLRS-South provides CHILD FIND services by searching for potentially exceptional students, ages 0-21; who are not currently being served, with emphasis on children 0-5 years of age .

A. Public Awareness: activities include media presentations on radio, television, and in the newspapers. Presentations are also made at various conferences and meetings.

B.Pre-School Screening: FDLRS/South also provides Pre-School Screening Clinics in cooperation with child-care centers, health department and other community agencies to locate children with disabilities. If you know of a child who is not in school and may be in need of special educational services, please call FDLRS-South, 274-3501.

C. Comprehensive Diagnostic Evaluations: FDLRS-South coordinates diagnostic services to CHILD FIND students requiring assessment.

These diagnostic inquiries may include: psycho-educational, speech and language, audiological, neurological, psychiatric, and other evaluations, as deemed necessary.

II. HUMAN RESOURCE DEVELOPMENT (HRD)

A. Inservice Training:
FDLRS-South provides Inservice Training, through workshops, conferences, and teleconferences, in the effective use of media and educational equipment; new teaching techniques and methods; and innovative instructional materials.

Workshops are directly related to the identified needs or interests of the Miami-Dade and Monroe County Exceptional Student Programs and are consistent with each school district's comprehensive system of personnel development. Workshops are announced in the FDLRS-South SUN **TIMES magazine**, on the MIS training Bulletin Board, and on the

FDLRS-South Web Site
Http:members.icanect
.net/~FDLRS-S.

B. Media/Materials:
FDLRS-South maintains an instructional materials center where special educators and parents can preview and borrow materials on a short-term basis. The collection includes diagnostic materials, teacher training, professional materials, and child-use instructional media and materials.

FDLRS-South staff assists in the identification, selection, acquisition, use and evaluation of media and materials appropriate for implementing instructional programs based on individualized Educational Plans (IEPs).

FDLRS-South maintains a microfiche collection of research in the field of special education, available for individual previewing. FDLRS-South also provides research services to special educators through the nationwide Education Research Information Center (ERIC), and the statewide Florida Resources in Education Exchange (FREE).

Visit the FDLRS-South Center at 5555 S.W. 93 Ave., Miami, and preview more than 8,000 items available for loan. Items may be borrowed by calling 274-3501. They may be sent and returned by school mail.

C. Information/Consultation
FDLRS-South acts as an information exchange network. Information is disseminated about the various exceptionality areas; about programs and services offered to exceptional children in Miami-Dade and Monroe Counties, about new technology applicable to exceptional students; and about meetings and conferences of interest to special educators and parents.

This information is available through the FDLRS-South **SUN TIMES** magazine. If you're a special educator, make sure you're on our **SUN TIMES** mailing list! Circulation: 5,000. Three times annually.

Parents of special needs children also receive free the trilingual **FAMILIES MATTER** newsletter (English, Spanish and Haitian Creole). Circulation: 30,000.

FDLRS-South's staff also provide consultation services concerning individual student needs or program support, on a request basis.

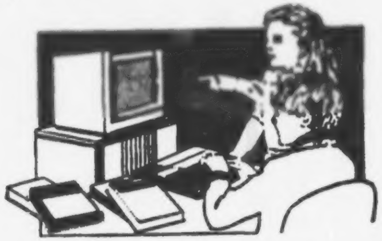
III. PARENT SERVICES

FDLRS-South assists in the development of partnerships between families and professionals which allows for shared responsibility for improving the education of children who have special needs.

These services include the publication of the trilingual **Families Matter** newsletter, parent education workshops, technical assistance, the Surrogate Parent Program and collaboration with other agencies.

IV. TECHNOLOGY

FDLRS-South maintains a Solutions Technology Laboratory, providing special educators and parents with training and guidance in the selection and use of both hardware and software for special populations.



Assistance is also provided in the identification and effective integration of assistive and adaptive technologies that meet the unique needs of exceptional children. Evaluations are provided for non-communicative students.

Appropriate augmentative and assistive devices are loaned, if needed, to enable students to communicate.

Adaptive Technology evaluations are provided for individuals who cannot access computers without adaptations.

FDLRS-South
(305) 274-3501
5555 S.W. 93 Ave.,
Miami, FL 33165

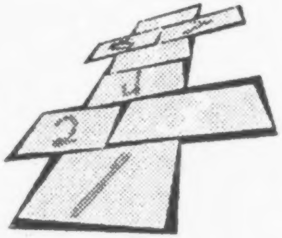
FDLRS-South
5555 S.W. 93 Avenue,
Miami, FL 33165
(305) 274-3501
Fax: (305) 598-7752

FDLRS-S Internet:
http://members.icanect.
net/~fdlrs

¿Cómo puedo aprovechar los servicios de FDLRS-Sur?

El Sistema de Diagnóstico y Recursos para el Aprendizaje-Sur es un sistema de ayuda disponible a educadores, administradores, universidades, agencias de la comunidad, escuelas privadas, padres y cualquier otro personal que esté involucrado en la educación de estudiantes que tienen necesidades especiales.

Llame a FDLRS-Sur al (305) 274-3501



FDLRS-South
FDLRS-Sur es uno de los 19 Centros Asociados en la Florida. El Sistema de Diagnóstico y Recursos de Aprendizaje (FDLRS) es auspiciado mediante fondos provenientes de IDEA, Parte B, para pre-escolares y a través de fondos provenientes de los ingresos generales del Estado para proveer servicios de apoyo a los estudiantes en programas de educación especial (ESE).

MIAMI-DADE COUNTY
PUBLIC SCHOOLS (M-DCPS)
1450 N.E. 2 Avenue, Miami, FL 33132

Roger C. Cuevas
Superintendente de Escuelas

Joseph H. Mathos
Superintendente Auxiliar para la Educación

Ronald K. Felton
Director de Distrito
Educación de Estudiantes Excepcionales
y Servicios Psicológicos

Alina C. Diaz, J.D.
Supervisora de Instrucción, FDLRS-Sur
(305) 274-3501

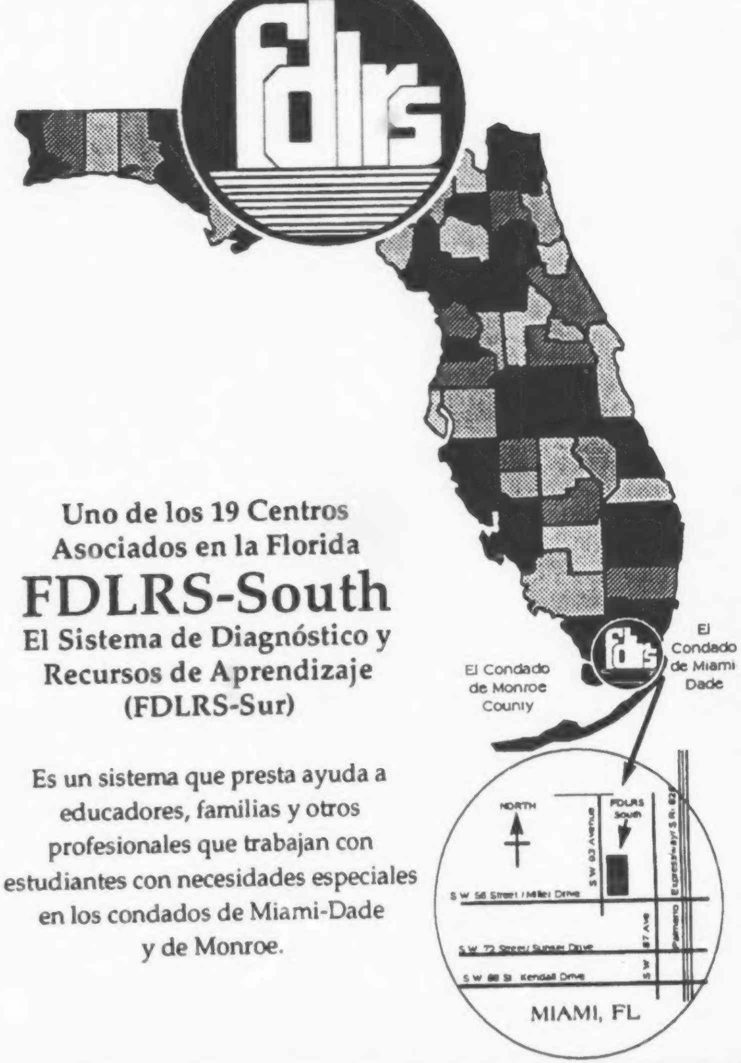
MONROE COUNTY
PUBLIC SCHOOLS
Michael Lannon
Superintendente de Escuelas

Doug E. Sayre
Director
Educación de Estudiantes Excepcionales

Linda Welsh
Especialista de CHILD FIND FDLRS-Sur
1400 United Street, Key West, FL 33040
(305) 293-1646

Un producto del Departamento Gráfico
FDLRS-South
Diseñado por Michelle Dreseris

El Sistema de Diagnóstico y Recursos de Aprendizaje-Sur


fdlrs
El Condado de Monroe County
El Condado de Miami Dade
NORTH
FDLRS South
S W 93 Avenue
S W 56 Street / Miller Drive
S W 72 Street / Sunset Drive
S W 88 St Kendall Drive
S W 87 Ave
Palmetto Expressway S.R. 826
MIAMI, FL

Uno de los 19 Centros
Asociados en la Florida

FDLRS-South

El Sistema de Diagnóstico y
Recursos de Aprendizaje
(FDLRS-Sur)

Es un sistema que presta ayuda a educadores, familias y otros profesionales que trabajan con estudiantes con necesidades especiales en los condados de Miami-Dade y de Monroe.

Horario: 8 a.m. – 4:30 p.m.
Todo el año. 5555 S.W. 93 Avenue, Miami, FL 33165.

¿Qué es FDLRS-SOUTH?

El Sistema de Diagnóstico y de Recursos de Aprendizaje del Sur de la Florida, (Florida Diagnostic and Learning Resources System-South, FDLRS-S), es administrado a través de la Oficina de Programas de Educación Excepcional de las Escuelas Públicas del Condado de Miami-Dade. Este es un sistema que presta ayuda a educadores, familias y otros profesionales que trabajan con estudiantes con necesidades especiales en los condados de Miami-Dade y de Monroe. Existen diecinueve centros de FDLRS en el Estado de la Florida. Dichos centros son coordinados por el Negociado de Apoyo Educacional y Servicios Comunitarios del Departamento de Educación Estatal.

¿Qué servicios se ofrecen en FDLRS-South?

I. CHILD-FIND

Programa de Identificación de Niños con Necesidades Especiales (CHILD-FIND): Esta unidad se encarga de identificar a los niños entre las edades de 0 a 21 años, con énfasis en los niños de 0 a 5 años, que no asisten a la escuela y de los que se sospecha tengan alguna necesidad especial.

A. Medios de comunicación: Se divulga información a través de diferentes medios de comunicación tales como: la radio, la televisión y la prensa. También, se hacen presentaciones en reuniones y en conferencias.

B. Clínicas de identificación de Preescolares:
Estas clínicas proveen servicios de pruebas preliminares (screening). Estos servicios se ofrecen en coordinación con las centros de cuidado infantil, el Departamento de Salud y otras agencias de la comunidad que identifican a niños con posibles necesidades especiales. Si conoce a algún niño que no esté en la escuela y que pueda tener alguna necesidad especial, favor de llamar al (305) 274-3501.

C. Evaluaciones Diagnósticas:
FDLRS-S coordina evaluaciones diagnósticas a aquellos niños que así lo requieran. Entre las mismas se encuentran evaluaciones psicoeducacionales, audiológicas, del habla y del lenguaje, neurológicas, psiquiátricas u otras.

II. Programa de Capacitación Profesional

(Human Resource Development, HRD)

A. El objetivo de este programa es enseñar mediante conferencias y adiestramientos el uso apropiado de la tecnología y de los recursos educativos existentes. Se presentan técnicas, métodos y materiales educativos innovadores. Las sesiones de capacitación responden a las necesidades e intereses identificados por los profesionales del Programa de Estudiantes de Educación Excepcional de los Condados de Miami-Dade y de Monroe.

B. Materiales Educativos Medios Audiovisuales:
FDLRS-S tiene un centro de materiales educativos donde los padres y los educadores pueden utilizar los materiales en calidad de préstamo a corto plazo. La colección incluye materiales de diagnóstico para adiestramientos de maestros y otros profesionales y materiales audiovisuales para uso con los niños. El personal de FDLRS-S ayuda en la identificación, selección, adquisición, uso y evaluación de materiales apropiados para la implementación de programas educativos basados en el Plan de Educación Individualizado (IEP). FDLRS-S mantiene una colección de microfichas de investigaciones en el campo de la educación especial. También, se proporcionan servicios de investigación a maestros de educación excepcional mediante el Centro de Investigaciones Educativas e Información (Education Research Information Center, ERIC).

C. Información/Consulta: FDLRS-S participa en una red de intercambio de información. La información es diseminada a los maestros sobre las diversas áreas de la educación excepcional; sobre programas y servicios ofrecidos en los condados de Miami-Dade y de Monroe a los niños con necesidades educativas especiales, así como la nueva tecnología disponible.

La revista de FDLRS-S SUN TIMES publica información sobre las reuniones y conferencias de interés para padres y los profesionales de la educación excepcional. Circulación: 5,000 ejemplares, tres veces al año.

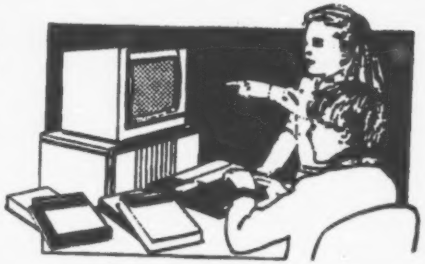
El personal de FDLRS-S ofrece también servicios de consultoría relacionados con las necesidades individuales de los estudiantes o programas de apoyo a estudiantes.

Los padres de niños con necesidades especiales reciben el periódico FAMILIES MATTER *Las Familias Importan*. Circulación: 30,000 ejemplares, dos veces al año.

III. Servicios a las Familias FDLRS-S:

FDLRS-S asiste en el desarrollo de asociaciones familias y profesionales, lo cual propicia una responsabilidad compartida hacia el mejoramiento de la educación de niños con necesidades especiales.

Los Servicios a las Familias incluyen la publicación del boletín trilingue Families Matter, conferencias de capacitación para familias, asesoría familiar individual y el Programa de Padres Sustitutos en Educación. Otra función importante de los Servicios a las Familias es fomentar la mutua colaboración con otras agencias comunitarias.



IV. Laboratorio de Tecnología:

Esta servicio es ofrecido mediante un laboratorio tecnológico, proveyendo a los padres y educadores capacitación y asesoramiento en la selección y uso de programas y computadoras para los estudiantes con necesidades especiales.

FDLRS-S proporciona sistemas tecnológicos de comunicación alterna para lograr que los estudiantes puedan comunicarse cuando la comunicación verbal es difícil o imposible.

Busca a FDLRS-South
en el Internet: Http:members.
Icanect.net/~FDLRS-S

FDLRS-S (305) 274-3501

Preki rgarten ESE Staff

Roni Bader-Tables, Instructional Supervisor
Dolores Mendoza, Parent Coordinator
(305) 271-5701

Prekindergarten Staffing Specialists

Josee Gregoire-Region I
(305) 687-6565

Robbie H. Dockswell-Region II
(305) 687-6565

Maria de la Vega-Region III
(305) 883-0401

Cecilia Nuñez-Region IV
(305) 271-5701

Marilyn Robinson-Region V
(305) 271-9881

Julissa Caso-Delgado-Region V
(305) 271-9881

Shelly Jacobs-Regions II, III, Iv
(305) 271-5701

Doreen Docobo-Region VI
(305) 271-5701

Freda Maryanoff (Part Time)
(305) 271-5701

Prekindergarten Bilingual Educational Specialist
Zilkia M. Rodriguez
(305) 271-5701

Part C LEA Liaison
Susan Werman
(305) 271-5701

Prekindergarten Speech/Language Pathologist Diagnosticians

Joan Reisinger
Regions I, II, III
(305) 995-2705

Paula Volpe
Regions IV, V, VI
(305) 271-9881

Pre-K Speech/Language Pathologist Case Review Specialist
Lonina McRae
(305) 271-5701

Birth-Two Staffing Specialists

Zoraida Salgado
(305) 271-9881

Millie Puig
(305) 271-9881

Prekindergarten School Psychologists
Teree Gomez
Janis Mikkelsen
(305) 271-9881

Prekindergarten Social Worker
Mary Jo Helm
(305) 271-9881

P.R.I.M.E. Time Specialists
(Prekindergarten Resource Instruction Mobile for Exceptional Education)

Sheila Miguel
(305) 271-9881

Mariela Johnson
(305) 271-9881

PPEC/Consulting Teacher
Edie Sachs
(305) 271-9881

The School Board iami-Dade County

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Dr. Michael M. Krop, Vice-Chair
Mr. G. Holmes Braddock
Dr. Robert B. Ingram
Ms. Betsy H. Kaplan
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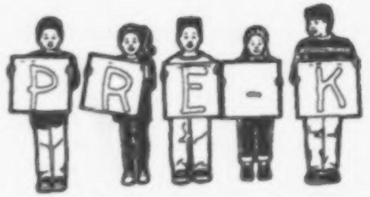
Superintendent of Schools

Mr. Joseph H. Mathos
Deputy Superintendent for Education

Mr. Ronald K. Felton, Assistant Superintendent
Office of Exceptional Student Education
and Psychological Services



For further information contact:
Roni Bader-Tables, Instructional Supervisor

Miami-Dade County Public Schools
Division of Exceptional Student Education
Prekindergarten Program for Children with Disabilities
5555 SW 93 Avenue - Trailer I
Miami, FL 33165
(305) 271-5701 · FAX (305) 598-5253

This publication was funded by the
Preschool Grant for Children with Disabilities Aged 3-5,
Part B, IDEA

Office of
Exceptional Student Education
and Psychological Services

Miami-Dade County Public Schools

PREKINDERGARTEN PROGRAM FOR CHILDREN WITH DISABILITIES

Miami-Dade County Public Schools' Exceptional Student Education (ESE) Program provides services for prekindergarten children with disabilities, ages 3 to 5. Children must be 3 years of age and have been evaluated to be eligible to enter the prekindergarten program. For evaluation information, contact the Child Find Specialist at (305) 274-3501.

Certified teachers work with prekindergarten children with the following disabilities:

- ○ autistic
- ○ developmentally delayed
- ○ dual sensory impaired
- ○ educable mentally handicapped
- ○ emotionally handicapped
- ○ deaf/hard of hearing
- ○ orthopedically impaired
- ○ other health impaired
- ○ profoundly mentally handicapped
- ○ severely emotionally disturbed
- ○ specific learning disabled
- ○ speech/language impaired
- ○ trainable mentally handicapped
- ○ traumatic brain injured
- ○ visually impaired

EDUCATIONAL ACTIVITIES

Prekindergarten children participate in a variety of educational activities during the school day, which runs from 8:30 a.m. to 2:00 p.m., Monday through Friday.

Prekindergarten children are active learners. They discover their world by direct experiences. Within our classrooms, the children are provided with opportunities to:

- ○ manipulate materials
- ○ choose activities
- ○ acquire skills with tools and equipment
- ○ solve problems
- ○ use small and large muscles
- ○ take care of one's own needs within a carefully planned daily routine.

PROGRAM OPTIONS

In view of the unique needs of young children and their families, five program models have been developed.

- ○ *Self-Contained Classroom*
- ○ *Cooperative Mainstreamed Program*
- ○ *Half-Day Prekindergarten Program*
- ○ *Speech/Language Impaired Half-Day Program*
- ○ *Hospital/Home-Bound Program*
- ○ *Walk-In Therapy for Speech/Language Program*

The following related services are available to prekindergarten children who meet eligibility guidelines:

- ○ Physical Therapy
- ○ Occupational Therapy
- ○ Orientation and Mobility

PE[illegible]NAL DEL PROGRAMA

Roni Bader-Tables, Supervisora de Instrucción
Dolores Mendoza,Coordinadora
(305) 271-5701

Especialistas en Asignación de Estudiantes

Robbie Dockswell-Región I
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Cecilia Nuñez-Región IV
(305) 271-5701

Marilyn Robinson-Región V
(305) 271-9881

Elaine Jessup-Región VI
(305) 271-5701

Julissa Caso-Delgado, Ph. D.-Región V
(305) 271-9881

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Millie Puig
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Patólogas del Habla

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Paula Volpe
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Psicóloga

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Trabajadora Social

Mary Jo Helm
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Especialista en Educación Bilingue

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Especialista de la Parte C

Susan Warman
(305) 271-5701

Especialistas de Recursos Educativos

Sheila Miguel
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Mariela Johnson
(305) 271-9881

Maestro de PPEC y de Consulta

Edie Sachs
(305) 271-9881

Junta Escolar Del Condado de Miami-Dade

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Dr. Michael M. Krop, Vicepresidente
Sr. G. Holmes Braddock
Sra. Perla Tabares-Hantman
Dr. Robert B. Ingram
Sra. Betsy H. Kaplan
Sra. Manty Sabatés Morse
Sr. Demetrio Pérez, Jr.
Dra. Marta Pérez

Sra. Monica V. Hunt, Asesor Estudiantil

Mr. Roger C. Cuevas
Superintendente de las Escuelas

Mr. Ronald K. Felton, Director del Districto
Oficina de Educación para Estudiantes
Excepcionales y Servicios Psicológicos

Para mas información llame:

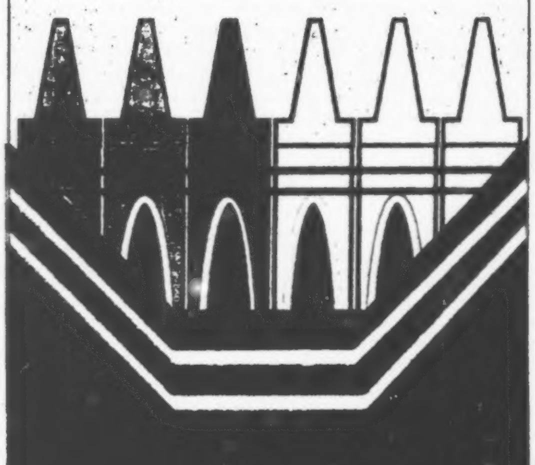
Escuelas Publicas del Condado de Miami-Dade
División de Educación de Estudiantes Excepcionales
Programa de Prekindergarten Para Niños Con Discapacidades
5555 SW 93 Avenue - Trailer 1
Miami, FL 33165
(305) 271-5701 ● FAX (305) 598-5253

Roni Bader-Tables, Supervisora de Instrucción

Esta publicación fué pagada por el
Preschool Grant for Children with Disabilities Aged 3-5,
Part B, IDEA

Oficina de Educación de
Estudiantes Excepcionales y
Servicios Psicológicos

Escuelas Públicas del Condado de Miami-Dade



PROGRAMA
DE
PREKINDERGARTEN
PARA NIÑOS
CON
DISCAPACIDADES

La División [illegible] Educación de Estudiantes Excepcionales de las Escuelas Públicas del Condado de Dade, ofrecen educación especial a niños con discapacidades de 3 a 5 años de edad. Para poder participar en el programa pre-escolar (prekindergarten), los niños deben haber cumplido 3 años y haber sido evaluados. Para información sobre evaluaciones llame al especialista de "Child Find" al (305) 274-3501.

Maestros especializados trabajan con niños que han sido diagnosticados con:

- ○ autismo
- ○ desorden emocional
- ○ desorden emocional severo
- ○ dificultad especifica para aprender
- ○ impedimento del habla/ lenguaje
- ○ impedimento doble sensorial
- ○ impedimento ortopédico
- ○ impedimento de salud
- ○ impedimento visual
- ○ lesión traumatica al cerebro
- ○ retraso en el desarrollo
- ○ retraso mental educable (ligero)
- ○ retraso mental adiestrable (moderado)
- ○ retraso mental grave (agudo)
- ○ trastorno auditivo

ACTIVIDADES EDUCACIONALES

Los niños del programa pre-escolar participan en una gran variedad de actividades durante el día escolar que comienza a las 8:30 A.M. y termina a las 2:00 P.M., de lunes a viernes.

Los niños pre-escolares descubren su mundo a través de experiencias directas con sus alrededores. En nuestras aulas, los niños tienen la oportunidad de:

- ○ manipular materiales
- ○ escoger actividades
- ○ adiestrarse con herramientas y equipo
- ○ resolver problemas
- ○ usar sus músculos grandes y pequeños
- ○ ocuparse de sus propias necesidades durante una rutina diaria planeada cuidadosamente

OPCIONES DEL PROGRA[illegible]S

Se han desarrollado cinco modelos de programas teniendo en cuenta las necesidades de los niños y de sus familias.

- ○ Aula Auto-Contenida
- ○ Programa Cooperativo Integrado
- ○ Programa Basado en el Hogar o el Hospital
- ○ Programa Durante Medio Día Para Niños con Discapacidades del Habla/Lenguaje
- ○ Programas de Terapia Solamente Para Niños que Vienen de Otros Lugares

Los siguientes servicios se ofrecen a los niños que llenan los requisitos:

- ○ Terapia Física
- ○ Terapia Ocupacional
- ○ Orientación y Movilidad
- ○ Terapia del Habla

From families...

"At mediation, everyone was listening and not ignoring what I said and an agreement was reached quickly."

"Thank you for the opportunity of mediation. We are very satisfied with the outcomes."

"The mediator gave us an opportunity to say what we felt and allowed us to get to the bottom of the problem."

From early intervention program representatives...

"Mediation shows that good faith efforts are attempted by all parties involved. To accommodate the parent, our mediation was held on a Saturday. I believe early intervention programs and providers must make whatever arrangements they can to attempt to resolve differences."

"The opportunity for creative problem-solving was taken advantage of by both parties here, and I think the skills of the mediator are largely responsible."

From mediators...

"Although we did not reach total agreement, there were positive outcomes. The parent and the program did improve their communication and make progress in understanding each other's position."

"I feel the process really works, even when both sides are committed to their position. You need to be persistent and believe that there is a solution for both sides."

Mediation is a confidential, non-adversarial process of resolving conflicts. In early intervention, mediation can assist families of young children with developmental delays and disabilities, early intervention programs, and agencies in resolving disagreements regarding early intervention services for an infant or toddler.

A trained mediator helps the parties reach a mutually satisfactory solution that is in the best interest of the family.

Mediation is voluntary, optional for both parties and completely confidential.

FLORIDA DEPARTMENT OF
HEALTH

Mediation In Early Intervention

Information for Parents

infants & toddlers
Early Intervention Program

Children's Medical Services
Florida Department of Health

What is Early Intervention Mediation?

Early intervention mediation is a way of resolving disagreements between families and early intervention personnel about early intervention services for infants and toddlers with disabilities. Mediation is an optional alternative to a due process hearing, is less costly and less adversarial.

Early intervention mediation can:

- resolve disagreements concerning identification, evaluation, or early intervention services for infants and toddlers
- clarify issues causing the disagreement.
- provide those involved with uninterrupted opportunities to present their point of view
- stimulate mutual problem-solving efforts.
- promote positive working relationships between families and early intervention programs
- help parents and early intervention program personnel focus on what they have in common - the young child - rather than on issues that divide them

How Does Mediation Work?

When parents and early intervention programs are unable to resolve their differences through the family support plan (FSP) process, they may request mediation. Both parties have to agree to mediation and sign a request form.

Mediation can occur before or at the same time that a request for a due process hearing is made. Mediation does not interfere with the right to a due process hearing or with due process timelines.

After a request for mediation is made, a mediator is assigned. The mediator contacts both parties and sets up a time and place for a mediation session. Generally, the mediation occurs within 14 days after the mediator is assigned. Mediation sessions generally last three to four hours.

Participants in a mediation session are the family and any personnel involved in providing early intervention services. Any party who has knowledge necessary to resolving the dispute may participate, but the number of participants is kept to a minimum.

Do Parents Have to Pay for Mediation?

In Florida, early intervention mediation is free to parents. Children's Medical Services covers the costs.

When both parties agree to mediation, they send a written request to:

Florida Department of Health
Children's Medical Services
Infants and Toddlers Early Intervention Program
4052 Bald Cypress Way, Bin #A06
Tallahassee, Florida 32399-1707
Fax: 850-414-7350

For more information about early intervention mediation, contact the Children's Medical Services, Infants and Toddlers Early Intervention Program; telephone: 850-245-4200.

CITRUS HEALTH NETWORK, INC.

Mental Illness can afflict anyone, rich, poor, young, old, Hispanic, Black or Anglo. Whether it is a child who can't function in school, a mother exhibiting signs of schizophrenia or a drug-dependent father who becomes part of South Florida's homeless "problem", it is not just the individual who suffers. It is the family, too, who watches this individual slip away from them, sinking deeper into isolation and hopelessness, that is equally devastated by mental illness.

Fortunately, many such families have long recognized that they have place to turn to for help.

Since 1979, Citrus Health Network, Inc., has been here for them, with an outstanding roster of licensed mental health care professionals who are totally committed to guiding the mentally ill and their families. We deal daily with tremendously complex problems. Our clients receive care from professionals who are not only highly educated in their respective fields, but who also have the patience and personality to work with the affected and his or her family to try to bring about positive, consistent change.

That is our goal at **Citrus Health Network, Inc.** We are proud of many successes we have enjoyed over the years, enabling and empowering the mentally ill and restoring them to their homes and dear ones

Citrus Health Network, Inc
MENTAL HEALTH SERVICES FOR ALL
4175 West 20th Avenue
Hilaleah, Florida 33012-1486

Citrus
HEALTH NETWORK, INC.

4175 West 20th Avenue
Hialeah, Florida 33012-1486
(305) 825-0300
www.citrushealth.org

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President & Chief Executive Officer

Maria A. Alonso, M.B.A.
Chief Operating Officer

Norma M. Campos, M.D.
Medical Director

Ana A. Rivas-Vazquez, PH.D., ABPP
Clinical Director

30564 7222.
referral.

CITRUS HEALTH NETWORK, INC.

Citrus Health Network, Inc. is a community mental health center providing inpatient and outpatient psychiatric services to Miami-Dade County residents.

EMERGENCY AND HOSPITALIZATION SERVICES

Adults and children in acute crisis receive immediate help 24 hours a day, seven days a week.

OUTPATIENT ASSESSMENT SERVICE

Assessment by Licensed mental health professionals including psychological evaluations for children and adults.

OUTPATIENT PSYCHIATRIC SERVICES

Outpatient psychiatric services are provided to children and adults. These services are provided by Licensed and Board Certified Psychiatrists.

- * 24 Hour Crisis Line (305) 825-0300
- * Psychiatric Evaluation and Screening
- * Short term Crisis Hospitalization

ADULT AND ELDERLY SERVICES

LICENSED RESIDENTIAL TREATMENT FACILITIES

For psychiatrically disabled adults, residential services provide a learning atmosphere which allows for gradual movement from homelessness to supervised settings and independent living. Movement depends on the individuals abilities, goals and resources. The following is a list of the Residential Programs available:

Winn Center(Levels I and II), KIVA, Shaman,
Ross Apartments (HUD),
Buena Vista (HUD) and
Independent Living (Shelter + Care)

ADULT DAY TREATMENT and PARTIAL HOSPITALIZATION PROGRAMS

Adult Day Treatment Programs are designed to help psychiatrically disabled individuals develop skills necessary to function as independently as possible in the community. Programs are offered throughout Miami Dade County.

CASE MANAGEMENT SERVICES

Case Management services are designed to provide additional supports to those individuals and families who require coordination of care and assistance with the development of care plans.

Payment
- Private Health Insurance
- Self Pay According to Income
- Florida Medicaid & Medicare

FAMILY AND CHILDREN SERVICES

LICENSED RESIDENTIAL PROGRAMS

Citrus Health Network provides residential services for children based on individual needs. The Specialized Therapeutic Foster Care program provides housing and outpatient and in-home services to children with many needs. The RITS program is an intensive residential program for adolescent males with involvement in the juvenile justice system.

SCHOOL AND COMMUNITY BASED TEAMS

The School and Community Based Teams is an outpatient treatment program, providing children with psychotherapeutic, case management and in-home respite care. The teams are based in the community at various Miami Dade County school sites from Homestead to North Dade.

CASE MANAGEMENT SERVICES and FAMILY SERVICES PLANNING TEAM

~~Case management services are provided to~~ children with multiple mental health needs. Many of the children are also involved with the Family Services Planning Team, a community based, multi disciplinary team which evaluates childrens' individualized needs and make recommendations for treatment in various community settings.

LICENSING AND ACCREDITATION
Licensed by the Agency for Healthcare Administration and accredited by the Joint Commission for Healthcare Organizations

CLAS COLLABORATORS

- ▶ University of Illinois at Urbana-Champaign
- ▶ ERIC Clearinghouse on Elementary and Early Childhood Education
- ▶ University of Wisconsin-Milwaukee
- ▶ The Council for Exceptional Children
- ▶ ERIC Clearinghouse on Disabilities and Gifted Education

The CLAS Institute is funded through a grant from the U.S. Department of Education's Offices of Special Education Programs.

FOR MORE INFORMATION

1/800.583.4135 ◀
v/tty

217.244.7732 ◀
fax

clas@uiuc.edu ◀
e-mail

http://clas.uiuc.edu ◀
web address

HOW DO I SUBMIT MATERIALS

SEND TWO COPIES OF YOUR WORK TO:

The Council for Exceptional Children
1920 Association Drive
Reston, VA 20191-1589
Attn: CLAS Acquisitions Coordinator

- ▶ **703.264.9488** *phone (v)*
- ▶ **703.264.9449** *tty*
- ▶ **703.620.2521** *fax*
- ▶ **clas@cec.sped.org** *e-mail*

We invite you to take part in a national effort to expand and improve early intervention services for culturally and linguistically diverse children and families.

C·L·A·S

Culturally & Linguistically Appropriate Services
EARLY CHILDHOOD RESEARCH INSTITUTE

WHAT IS CLAS ?

We are collecting and describing materials that are useful to all those involved in the lives of young children and their families.

The Early Childhood Research Institute on Culturally and Linguistically Appropriate Services (CLAS) is a federally-funded collaborative effort to improve the services provided to young children with disabilities and their families.

http://clas.uiuc.edu

THE CLAS WEBSITE provides information on serving culturally and linguistically diverse children and families, including:

- resource library of reviewed materials
- guidelines for choosing materials
- tips on how to develop new services or change some of your current services
- literature review papers
- bibliographies/annotated bibliographies
- links to related Internet sites

THE CLAS INSTITUTE

▸ ▸ ▸

- Collects culturally and linguistically appropriate materials for early intervention and preschool services and maintains this resource library.
- Conducts reviews of materials by experts in the fields of early childhood education, early intervention-early childhood special education, bilingual education, and multicultural education.
- Disseminates information on reviewed materials and practices that meet the dual criteria of (a) effectiveness and (b) cultural and linguistic appropriateness.

WHAT MATERIALS SHOULD I SEND?

The CLAS Institute seeks your early childhood materials in both English and other languages in *PRINT, VIDEO, AUDIO, AND MULTIMEDIA*. For example:

- training materials for early childhood personnel
- information packets for parents and teachers
- resource materials or curriculum guides
- awareness materials

WHY SEND MATERIALS TO CLAS?

- CLAS will disseminate information about your work to a wide audience in a database that will be available on the Internet, in print, and on CD-ROM.
- The CLAS resources will be used extensively by administrators, teachers, researchers, students, parents, and the general public.
- You can receive valuable feedback from users of your material.

TOPICS

Materials should generally fall into one or more of these categories:

- child assessment
- child find
- child instruction
- family services
- personnel preparation

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INDIVIDUALS WITH DISABILITIES EDUCATION ACT (I.D.E.A.)
(LA LEY PARA LAS PERSONAS CON DISCAPACIDADES)

RECURSOS PARA PADRES

PARA INFORMACION ADICIONAL SOBRE LOS DERECHOS DE LOS PADRES EN I.D.E.A.SE PUEDE PONER EN CONTACTO CON LAS SIGUIENTES ORGANIZACIONES:

PARENT TO PARENT OF MIAMI, INC."COMMUNITY PARENT RESOURCE CENTER"
c/o Sunrise Community, Suite G
9040 Sunset Drive
Miami, Florida 33173
(305) 271-9797

FDLRS SOUTH / RECUSRSOS PARA LOS PADRES
5555 S.W. 93rd Avenue
Miami, Florida 33165
(305) 274-3501

COMMUNITY COMMITTEE FOR DEVELOPMENTAL HANDICAPS (CCDH)
7925 N.W.12th Street, Suite 325
Miami, Florida 33126
(305) 594-4466

FAMILY NETWORK ON DISABILITIES
2735 Whitney Road
Clearwater, Florida 33760-1610
(305) 412-1227

THE ADVOCACY CENTER FOR PERSONS WITH DISABILITIES, INC.
2901 Stirling Road, Suite 206
Ft. Lauderdale, Florida 33312
(800) 342-0823

LEGAL SERVICES OF GREATER MIAMI, INC.
3000 Biscayne Blvd, Suite 500
Miami, Florida 33137
(305) 576-0080

UNIVERSITY OF MIAMI CHILDREN & YOUTH LAW CLINIC
5915 Ponce de Leon Blvd., Suite 28
Coral Gables, Florida 33146
(305) 284-3123

Miami-Dade County Public Schools
Office of Exceptional Student Education & Psychological Services
(305) 995-1799

¿QUE ES PADRE A PADRE DE MIAMI ?

Es un programa de apoyo para padres que tienen un hijo o hija con discapacidades en el desarrollo tal como autismo, parálisis cerebral, sindrome Down, epilepsia, retraso mental, espina bifida, discapacidades como las visuales, audiologicas, la hypertividad, y convulsiones.

La misión de Padre a Padre de Miami es crear y sostener una red de padres que tienen el interes común de ayudar a sus hijos a obtener el potencial máximo y lograr que puedan vivir lo mas independiente posible.

Padre a Padre de Miami crea la red de padres que tienen hijos con discapacidades y les apoya ofreciéndoles información, educación, entrenamiento, e intercede por las familias ante diferentes programas o agencias.

Padre a Padre de Miami es patrocinado en su mayoria por fondos del U.S.. Departamento de Educación (OSEP) Oficina de Programas de Educación Especial. Otros fondos incluyen subsidios, donaciones y voluntarios.

¿QUE PUEDE HACER PADRE A PADRE DE MIAMI POR USTED?

- Proveer apoyo emocional y compartir experiencias con otros padres quienes tambien se han adaptado a las necesidades de su hijo.
- Ofrecer puntos de enlace con servicios comunitarios y profesionales.
- Brindar información actualizada relacionada con diferentes discapacidades.
- Le ayuda a identificar opciones para servicios, educación y otros programas para su hijo y usted.
- Les ofrece la oportunidad de tener a un padre de apoyo que es compasivo, sensitivo y entrenamiento para escucharle y ayudarle, porque ellos también han pasado por su misma situación.

SERVICIOS

- Información sobre discapacidades especificas
- Educación y Entrenamiento
- Asistencia y orientación en momentos dificiles
- Enlace con un " padre de apoyo"
- Boletín con artículos en Español
- Grupos de apoyo en Español
- Recursos en la comunidad
- Biblioteca
- Seminarios

¿QUIEN PUEDE REFERIR A UNA FAMILIA?

- Padres
- Enfermeros
- Doctores
- Trabajadores sociales
- Amigos
- Educadores
- Familiares
- Maestros
- Otras entidades

Para más información llamar:

Tel: 305-271-9797
Fax: 305-271-6628
Para el Condado de Monroe 1-800-527-9552

Y pida hablar con la Orientadora y Coordinadora de Servicios a Familias

"Community Parent Resource Center"

PARENTS HELPING PARENTS

If your child
has special needs,
you may too....

Serving Miami- Dade & Monroe Counties

PARENT TO PARENT of MIAMI

"Centro Comunitario de Recursos Para Padres"

PADRES AYUDANDO A PADRES

Si su hijo tiene
necesidades especiales,
quizás usted tambien....

Sirviendo los Condados de
Miami - Dade y Monroe

Name(Nombre)..........

Address (Dirección)..........

City (Ciudad)..........

State(Estado)..........

Zip Code(Código Postal)..........

Tel (Teléfono)..........

Fax..........

E-Mail..........

☐ Parent (Padre/ Madre)

☐ Professional (Profesional)

☐ I'm interested in becoming a supportive parent. (Estoy interesado en ser padre de apoyo.)

☐ Please accept my enclosed membership dues. (Favor de acceptar mi contribución como miembro.)

- Basic annual membership (Cuota anual básica) $18.
- Donor (Donante) $25.
- Benefactor (Benefactor) $50.
- Champion (Campeón) $100.
- Other (Otro)..........

Please complete this form (Favor de llenar el formulario)Return to (envie a):

Parent to Parent of Miami, Inc.
c\o Sunrise Community
9040 Sunset Drive, Suite G
Miami, Florida 33173

Tel: 305-271-9797
Fax: 305-271-6628
1-800-527-9552 for Monroe County
E-mail: ptop1086@aol.com
Website: www.PtoPMiami.org

We will not deny membership due to inability to pay.

WHAT IS PARENT TO PARENT OF MIAMI?

Parent to Parent of Miami, Inc. is a program for parents who have children and adults with a developmental disability such as autism, cerebral palsy, down syndrome, epilepsy, mental retardation, spina bifida, and other special needs such as vision or hearing impairment, hyperactivity, seizure disorder or developmentaldelays as a result of prematurity.

The mission of Parent to Parent of Miami is to build and sustain an active network of parents whose common interest in their children binds them together to help their children achieve their highest potential and live as independent as possible.

Parent to Parent of Miami, Inc., creates a network of families who have members with disabilities and supports those families by providing information, training, peer support, education, advocacy & emergency assistance.

Parent to Parent of Miami, Inc. is primarily funded by a grant from the U.S. Department of Education (OSEP) Office of Special Education Programs. Other funding sources include grants, donations, volunteer parents and professionals.

PARENT TO PARENT OF MIAMI IS:

Parents who have first hand experience parenting a child with a disability, offering support to other parents by:

Answering questions & providing resources

Referring parents to community agencies,

Empathizing in a way that only another parent "who has been there" can do,

Nurturing and encouraging one another in a supportive reciprocal relationship,

Talking things over the telephone or over a cup of coffee,

Sharing ongoing growth and experiences.

SERVICES

- Information on specific disability
- Education & Training
- Advocacy & emergency assistance
- Match with supportive parent
- Bilingual newsletter
- Educational rights training
- Family support training
- Support Groups
- Community Resources
- Bilingual lending library
- Seminars

WHO CAN GET INFORMATION OR REFER A FAMILY:

- Parents
- Nurses
- Doctors
- Clergymen
- Social Workers
- Friends
- Teachers
- Relatives

For more information please contact:

Tel: 305-271-9797
Fax: 305-271-6628
1-800-527-9552 for Monroe County

Ask to speak to a Family Support Coordinator & Parent Trainer who will assist you in English, Spanish or Creole

SCHOOL SCREENING PROGRAM

The Hearing and Speech Center of Florida takes pride in its comprehensive screening program, the first of its kind in South Florida, which has evolved into a complete battery utilizing the latest techniques and technology. A team of Speech-Language Pathologists, Audiologists, and Psychologists provide screenings in the following areas:

Speech:
Articulation of sounds and words in sentences.

Language:
Understanding of language concepts and use of correct grammatical patterns.

Hearing:
Pure-tone assessment of hearing acuity. Tympanometry assessment of middle ear function.

Vision:
Assessment of visual acuity.

Psycho-Educational:
Pre-academic skills screening is available on an individual basis.

© Bob Suto

Therapy is available at our Centers or at your school. Presentations and in-services for parents and teachers on speech and language development and possible problems are offered at schools. In addition, medical and educational follow-ups are facilitated rapidly due to our extensive networking in the community.

Early detection of a problem can prevent delays in a child's normal development. Speech, language and vision are the foundation for all future learning. For further information, please call our Center at 305.446.5597.

OTHER
HEARING AND SPEECH CENTER
SERVICES:

Complete Speech and Language Assessment

◆

Audiological Testing

◆

Hearing Aids & Assistive Listening Devices

◆

Lipreading Classes

◆

School and Hospital Screenings

◆

Occupational Therapy

◆

Accent and Dialect Reduction

◆

Public Speaking

HEARING AND SPEECH CENTER
OF FLORIDA, INC.
2511 Ponce de Leon Blvd., Suite 203
Coral Gables, Florida 33134-6812
Telephone: 305.446.5597 VOICE/TDD
Fax: 305.448.0235 Email: HSCF@aol.com

Satellite South Dade Office:
27501 S. Dixie Highway, Suite 403
Naranja, Florida 33032

UNITED WAY

SCREENING
SPEECH
Language
Vision
HEARING
LEARNING
PREV
Iden
Referral
PARENT EDUCATION
Speech
Language
Vision
HEARING
LEARNING
PREVENTION
Identification
Referral
Speech
Language
Vision
[illegible]

[illegible]

BEST COPY AVAILABLE

Online Resources

ONLINE RESOURCES

Acoustic Neuroma Association
URL: http://132.183.175.10/ana/
e-mail: anausa@aol.com

American Cancer Society
URL: http://www.cancer.org/

Association of Pediatric Oncology Nurses (APON)
URL: http://www.apon.org/

Cancer Net (National Cancer Inst.)
URL: http://cancernet.nci.nih.gov/

Candlelighters Childhood Cancer Family Alliance
URL: http://www.candle.org/

Council for Exceptional Children (CEC)
URL: http://www.cec.sped.org

Dystonia Medical Research Foundation
URL: http://www.iii.net/biz/dystonia.html
e-mail: dystfdtn@aol.com

Early Childhood Research Institute on Service Utilization ECRI:SU
URL: http://www.unc.edu/depts/ecri

EDLAW This site is a source for full texts of the Individuals with Disabilities Education Act (IDEA), Section 504, regulations, IEP questions and answers. It also features a list of attorneys who represent parents of children with disabilities. The list, arranged alphabetically by state, includes names, addresses, phone numbers, years in practice, fees, etc. (301) 983-2543
URL: http://www.access.digex.net/~edlawinc/

Federation of Families for Children's Mental Health (FFCMH)
URL: http://www.ffcmh.org
e-mail: ffcmh@crosslink.net

Hemophilia Related Organizations
URL: http://www.web-depot.com.hemophilia/organizations.html

Human Growth Foundation
URL: http://www.medhelp.org/web/hgf.htm
e-mail: hgfound@erols.com

LD (Learning Disabilities) On-Line
URL: http://www.ldonline.org
e-mail: LDOnLine@weta.com

Leukemia Society of America
URL: http://www.leukemia.org/

LRP Publications; Special Education Law Publications
URL: http://www.lrp.com/ed
e-mail: custserve@lrp.com

MAGIC Foundation for Children's Growth
URL: http://www.nettap.com/~magic

Make A Wish Foundation
URL: http://www.wish.org

National Adrenal Diseases Foundation
URL: http://medhlp.netusa.net/www/nadf.htm
e-mail: nadf@aol.com

National Clearinghouse for Professions in Special Education (NCPSE)
URL: http://www.cec.sped.org/ncps.htm
e-mail: ncpse@cec.sped.org

Americans With Disabilities Act Information on the Web

Americans With Disabilities Act Home Page

Americans With Disabilities Act

Americans With Disabilities Act: Q&A

ADA Title II Technical Assistance Manual

ADA Title II Technical Assistance Manual Supplement

ADA Title III Technical Assistance Manual

ADA Title III Technical Assistance Manual Supplement

Nondiscrimination on the Basis of Disability in State and Local Government Services

Part 36 -- Nondiscrimination Based on Disability by Public Accomadations and in Commercial Facilities

Enforcement Highlights: Fighting Discrimination Against Persons with HIV /AIDS

Proposed Rule, 28 CFR Part 35 - Requirement for Curb Ramps - Extended Public Comment Period

Americans with Disabilities Act Accessibility Guidelines; Detectable Warnings

Proposed Rule, 28 CFR Part 35 - Requirement for Curb Ramps - Extended Public Comment Period

Proposal to Amend Title II of the Americans With Disabilities Act

"Enforcement Highlights: Fighting Discrimination Against Persons with HIV/AIDS"

"Questions & Answers - The ADA and Persons with HIV/AIDS"

Learn About the ADA in Your Local Library

Myths And Facts About The Americans With Disabilities Act

Americans With Disabilities Act of 1990, P.L. 101-336

Common Questions about Title II of the ADA

Association for the Care of Children's Health (ACCH)
7910 Woodmont Avenue, Suite 300
thesda, MD 20814-3015
800) 808-2224; (301) 654-6549 (Voice)
-mail: acch@clark.net
URL: http://acch.org

Association for Persons with Severe Handicaps (TASH)
29 W. Susquehanna Ave., Suite 210
Baltimore, MD 21204
(410) 828-8274 (Voice); (410) 828-1306 (TTY)
E-mail: info@tash.org
URL: http://www.tash.org

Attention Deficit Disorder Association (ADDA)
P.O. Box 972
Mentor, OH 44061
(216) 350-9595
(800) 487-2282 (To request information packet)
E-mail: NATLADDA@aol.com
URL: http://www.add.org

Autism Society of America (formerly NSAC)
7910 Woodmont Avenue, Suite 650
Bethesda, MD 20814-3015
(800) 3-AUTISM; (301) 657-0881 (Voice)
Fact sheet available in Spanish
RL: http://www.autism-society.org

Brain Injury Association
(formerly the National Head Injury Foundation)
1776 Massachusetts Ave., N.W., Suite 100
Washington, D.C. 20036
(202) 296-6443
Publications available in Spanish
URL: http://www.biausa.org

Children and Adults with Attention Deficit Disorders (CH.A.D.D.)
499 NW 70th Avenue, Suite 101
Plantation, FL 33317
(954) 587-3700
(800) 233-4050 (To request information packet)
URL: http://www.chadd.org

Council for Exceptional Children (CEC)
1920 Association Drive
Reston, VA 20191-1589
(703) 620-3660 (Voice); (703) 264-9446 (TTY)
E-mail: cec@cec.sped.org
URL: http://www.cec.sped.org/home.htm

isability Rights and Education Defense Fund
212 Sixth Street
Berkeley, CA 94710
(510) 644-2555 (Voice); (510) 644-2626 (TTY)
E-mail: dredf.pa@aol.com

Disability Statistics Rehabilitation, Research and Training Center
Institute for Health and Aging
Box 0646 Laurel Heights, UCSF
San Francisco, CA 94143-0646
(415) 502-5210 (Voice); (415) 502-5217 (TTY)
E-mail: information_specialist@quickmail.ucsf.edu
URL: http://dsc.ucsf.edu

Epilepsy Foundation of America (EFA)
4351 Garden City Drive, 5th Floor
Landover, MD 20785-4941
(800) 332-1000; (301) 459-3700
Publications available in Spanish
Spanish speaker on staff
E-mail: postmaster@efa.org
URL: http://www.efa.org

Family Resource Center on Disabilities
20 East Jackson Boulevard, Room 900
Chicago, IL 60604
(800) 952-4199 (Voice/TTY; toll-free in IL only)
(312) 939-3513 (Voice); (312) 939-3519 (TTY)

Family Village
(a global community of disability-related resources)
Waisman Center
University of Wisconsin-Madison
1500 Highland Avenue
Madison, WI 53705-2280
URL: http://www.familyvillage.wisc.edu/

Family Voices
P. O. Box 769
Algodones, NM 87001
(505) 867-2368
E-mail: famv01rw@wonder.em.cdc.gov
URL: www.ichp.ufl.edu/MCH-NetLink/FamilyVoices

Head Start Bureau
Administration on Children, Youth and Families
U.S. Department of Health & Human Services
P.O. Box 1182
Washington, D.C. 20013
(202) 205-8579

Hydrocephalus Association
870 Market Street #955
San Francisco, CA 94102
(415) 732-7040
E-mail: hydroassoc@aol.com
URL: http://neurosurgery.mgh.harvard.edu/ha/

National Neurofibromatosis Foundation
95 Pine Street; 16th Floor
New York, NY 10005
(800) 323-7938; (212) 344-NNFF
E-Mail: NNFF@aol.com
URL: http://www.nf.org

National Parent Network on Disabilities
1727 King Street, Suite 305
Alexandria, VA 22031
(703) 684-6763 (Voice/TTY)
E-Mail: npnd@cs.com
URL: http://www.npnd.org

National Parent to Parent Support and Information System, Inc.
P.O. Box 907
Blue Ridge, GA 30513
(800) 651-1151; (706) 632-8822
E-mail: Judd103w@wonder.em.cdc.gov
URL: http://www.nppsis.org

National Patient Air Transport Hotline
P.O. Box 1940
Manassas, VA 20108-0804
(800) 296-1217
E-Mail: npathmsg@aol.com
URL: http://www.npath.org

National Scoliosis Foundation
5 Cabot Place
Stoughton, MA 02072
(800) 673-6922; (617) 341-6333
E-mail: scoliosis@aol.com

National Sleep Foundation
729 15th Street, NW
4th Floor
Washington, DC 20005
(202) 347-3471
E-mail: natsleep@erols.com
URL: http://www.sleepfoundation.org

National Spinal Cord Injury Association
8300 Colesville Road, Suite 551
Silver Spring, MD 20910
(800) 962-9629; (301) 588-6959
E-mail: nscia2@aol.com
URL: http://www.spinalcord.org

National Tuberous Sclerosis Association
8181 Professional Place, Suite 110
Landover, MD 20785-2226
(800) 225-6872; (301) 459-9888
E-mail: ntsa@aol.com
URL: http://www.ntsa.org/

Neurofibromatosis, Inc.
8855 Annapolis Road, Suite 110
Lanham, MD 20706-2924
(800) 942-6825
E-mail: NFinc@gnn.com
URL:

Orton Dyslexia Society
Chester Building # 382
8600 LaSalle Road
Baltimore, MD 21286-2044
(800) 222-3123; (410) 296-0232
E-mail: info@ods.org
URL: http://www.ods.org

Osteogenesis Imperfecta Foundation
804 Diamond Ave., Suite 210
Gaithersburg, MD 20878
(800) 981-BONE
E-mail: bonelink@aol.com
URL: http://users.aol.com/bonelink

Parents Helping Parents:
The Parent-Directed Family Resource Center for Children with Special Needs
3041 Olcott St.
Santa Clara, CA 95054
(408) 727-5775
Publications available in Spanish
Spanish speaker on staff
E-mail: info@php.com
URL: http://www.php.com

President's Committee's Job Accommodation Network
West Virginia University
918 Chestnut Ridge Road, Suite 1
P.O. Box 6080
Morgantown, WV 26506-6080
(800) 526-7234 (Voice/TTY)
(800) 232-9675 (Voice/TTY, information on the ADA)
E-mail: jan@.iedi.wvu.edu
URL: http://janweb.icdi.wvu.edu

Recording for the Blind and Dyslexic
The Anne T. Macdonald Center
20 Roszel Road
Princeton, NJ 08540
(800) 221-4792; (609) 452-0606
URL: http://www.rfbd.org

Sibling Information Network
A.J. Pappanikou Center
University of Connecticut
249 Glenbrook Road, U64
Storrs, CT 06269-2064
(860) 486-5035
Spanish speaker on staff

Fact Sheets from the National Information Center for Children and Youth with Disabilities - NICHCY

NICHCY

National Information Center for Children and Youth with Disabilities
P.O. Box 1492, Washington, D.C. 20013-1492
1-800-695-0285 (Toll Free, Voice/TT)
*SpecialNet User Name: NICHCY ** SCAN User Name: NICHCY*

General Information About

CEREBRAL PALSY

Definition

Cerebral palsy is a condition caused by damage to the brain, usually occurring before, during or shortly following birth. "Cerebral" refers to the brain and "palsy" refers to a disorder of movement or posture. Cerebral palsy is neither progressive nor communicable. It is also not "curable" in the accepted sense, although education, therapy, and applied technology can help persons with cerebral palsy lead productive lives. It is not a disease and should never be referred to as such. It can range from mild to severe.

The causes of cerebral palsy include illness during pregnancy, premature delivery, or lack of oxygen supply to the baby. It may occur early in life as a result of an accident, lead poisoning, viral infection, child abuse, or other factors. Chief among the causes is an insufficient amount of oxygen or poor flow of blood reaching the fetal or newborn brain. This can be caused by premature separation of the placenta, an awkward birth position, labor that goes on too long or is too abrupt, or interference with the umbilical cord. Other causes may be associated with premature birth, RH or A-B-O blood type incompatibility between parents, infection of the mother with German measles or other viral diseases in early pregnancy, and microorganisms that attack the newborn's central nervous system. Lack of good prenatal care may also be a factor. A less common type is acquired cerebral palsy: Head injury is the most frequent cause, usually the result of motor vehicle accidents, falls, or child abuse.

Incidence

Between 500,000 - 700,000 Americans have some degree of cerebral palsy. About 3,000 babies are born with the disorder each year, and another 500 or so acquire it in the early years of life.

Characteristics

There are three main types of cerebral palsy: spastic—stiff and difficult movement; athetoid— involuntary and uncontrolled movement; and ataxic—disturbed sense of balance and depth perception. There may be a combination of these types for any one individual. Other types do occur, although infrequently.

Cerebral palsy is characterized by an inability to fully control motor function. Depending on which part of the brain has been damaged and the degree of involvement of the central nervous system, one or more of the following may occur: spasms; tonal problems; involuntary movement; disturbance in gait and mobility; seizures; abnormal sensation and perception; impairment of sight, hearing, or speech; and mental retardation.

Developmental, Educational, and Employment Implications

Early identification of cerebral palsy can lessen developmental problems and lead to appropriate intervention when it helps the most. Early intervention programs are family-centered, and professionals and families work together with the child in specific activities. Educators, physical and occupational therapists, social workers, speech-language pathologists, psychologists, and physicians can assist families by providing information and education.

Activities for children with cerebral palsy may include:

- speech and language therapy;
- occupational therapy;
- physical therapy;
- medical intervention;
- family support services;
- early education; and
- assistive technology.

As a child gets older and begins formal schooling, the intensity of services will vary from individual to individual. Persons with cerebral palsy are usually able to attain a substantial degree of independence but, in some cases, may need considerable assistance. Services for the school-age child may include continuing therapy, regular or special education, counseling, technical support, community integration opportunities, recreation, and possible personal attendants. A key factor seems to be a supportive family. People extensively affected by cerebral palsy can still be highly functional and independent. The HEATH Resource Center (the clearinghouse on postsecondary education for individuals with disabilities) states that a significant number of students with cerebral palsy are enrolled in colleges and universities.

Important advances have taken place in the last 15 years which have had a great effect on the long-term well-being of children born with cerebral palsy. Advanced technology, including computers and engineering devices, has been applied to the needs of persons with cerebral palsy. Technological innovations have been developed in the areas of speech and communication, self-care, and adapting living arrangements and work sites. The future may bring even more significant applications.

Another important development has been the increased ability of persons with disabilities, including those who have cerebral palsy and other severe disabilities, to live independently in the community. Adults with cerebral palsy are now living, with or without assistance, in their own apartments or townhouses. Independent Living Centers have also proven to be important resources for persons with disabilities.

Resources

Geralis, E. (1991). *Children with cerebral palsy, A parent's guide.* Rockville, MD: Woodbine House. [Contact Woodbine House at 1-800-843-7323 (outside DC area) or (301) 468-8800 (in DC area)].

Schleichkorn, J. (1983). *Coping with cerebral palsy: Answers to questions parents often ask.* Austin, TX: Pro-Ed. [Contact Pro-Ed at (512) 451-3246.]

Weiss, S. (1993). *Each of us remembers: Parents of children with cerebral palsy answer questions.* Washington, DC: United Cerebral Palsy Associations, Inc. (See UCPA telephone number and address below.)

Organizations

American Academy for Cerebral Palsy and
Developmental Medicine
1910 Byrd Avenue, Suite 100
P.O. Box 11086
Richmond, VA 23230-1086
(804) 282-0036 (For physician referral)

Independent Living Residential Utilization Project
(ILRU)
The Institute for Rehabilitation and Research
2323 South Sheppard, Suite 1000
Houston, TX 77019
(713)520-0232; (713) 520-5136 (TT)

National Easter Seal Society
70 East Lake Street
Chicago, IL 60601
(312) 726-6200; (312) 726-4258 (TT)
(800) 221-6827 (Outside IL)

National Rehabilitation Information Center
(NARIC)
8455 Colesville Road, Suite 935
Silver Spring, MD 20910-3319
(301) 588-9284 (V/TT); (800) 346-2742

United Cerebral Palsy Associations, Inc.
1522 K Street, N.W., Suite 1112
Washington, D.C. 20005
(202) 842-1266 (V/TT); (800) 872-5827 (V/TT)

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UPDATE 12/93

Fact Sheet Number 4 (FS4), 1993

NICHCY
National Information Center for Children and Youth with Disabilities
P.O. Box 1492, Washington, D.C. 20013-1492
1-800-695-0285 *(Toll Free, Voice/TT)*
*SpecialNet User Name: NICHCY ** SCAN User Name: NICHCY*

General Information About
DOWN SYNDROME

Definition

Down syndrome is the most common and readily identifiable chromosomal condition associated with mental retardation. It is caused by a chromosomal abnormality: for some unexplained reason, an accident in cell development results in 47 instead of the usual 46 chromosomes. This extra chromosome changes the orderly development of the body and brain. In most cases, the diagnosis of Down syndrome is made according to results from a chromosome test administered shortly after birth.

Incidence

Approximately 4,000 children with Down syndrome are born in the U.S. each year, or about 1 in every 800 to 1,000 live births. Although parents of any age may have a child with Down syndrome, the incidence is higher for women over 35. Most common forms of the syndrome do not usually occur more than once in a family.

Characteristics

There are over 50 clinical signs of Down syndrome, but it is rare to find all or even most of them in one person. Some common characteristics include:

- Poor muscle tone;
- Slanting eyes with folds of skin at the inner corners (called epicanthal folds);
- Hyperflexibility (excessive ability to extend the joints);
- Short, broad hands with a single crease across the palm on one or both hands;
- Broad feet with short toes;
- Flat bridge of the nose;
- Short, low-set ears;
- Short neck;
- Small head;
- Small oral cavity; and/or
- Short, high-pitched cries in infancy.

Individuals with Down syndrome are usually smaller than their nondisabled peers, and their physical as well as intellectual development is slower.

Besides having a distinct physical appearance, children with Down syndrome frequently have specific health-related problems. A lowered resistance to infection makes these children more prone to respiratory problems. Visual problems such as crossed eyes and far- or nearsightedness are higher in individuals with Down syndrome, as are mild to moderate hearing loss and speech difficulty.

Approximately one third of babies born with Down syndrome have heart defects, most of which are now successfully correctable. Some individuals are born with gastrointestinal tract problems that can be surgically corrected.

Some people with Down syndrome also may have a condition known as Atlantoaxial Instability, a misalignment of the top two vertebrae of the neck. This condition makes these individuals more prone to injury if they participate in activities which overextend or flex the neck. Parents are urged to have their child examined by a physician to determine whether or not their child should be restricted from sports and activities which place stress on the neck. Although this misalignment is a potentially serious condition, proper diagnosis can help prevent serious injury.

Children with Down syndrome may have a tendency to become obese as they grow older. Besides having negative social implications, this weight gain threatens these individuals' health and longevity. A supervised diet and exercise program may help reduce this problem.

Educational and Employment Implications

Shortly after a diagnosis of Down syndrome is confirmed, parents should be encouraged to enroll their child in an infant development/early intervention program. These programs offer parents special instruction in teaching their child language, cognitive, self-help, and social skills, and specific exercises for gross and fine motor development. Research has shown that stimulation during early developmental stages improves the child's chances of developing to his or her fullest potential. Continuing education, positive public attitudes, and a stimulating home environment have also been found to promote the child's overall development.

Just as in the normal population, there is a wide variation in mental abilities, behavior, and developmental progress in individuals with Down syndrome. Their level of retardation may range from mild to severe, with the majority functioning in the mild to moderate range. Due to these individual differences, it is impossible to predict future achievements of children with Down syndrome.

Because of the range of ability in children with Down syndrome, it is important for families and all members of the school's education team to place few limitations on potential capabilities. It may be effective to emphasize concrete concepts rather than abstract ideas. Teaching tasks in a step-by-step manner with frequent reinforcement and consistent feedback has proven successful. Improved public acceptance of persons with disabilities, along with increased opportunities for adults with disabilities to live and work independently in the community, have expanded goals for individuals with Down syndrome. Independent Living Centers, group-shared and supervised apartments, and support services in the community have proven to be important resources for persons with disabilities.

Resources

Brill, M.T. (1993). *Keys to parenting a child with Down syndrome*. Hauppauge, NY: Barron's.

National Down Syndrome Congress. (1988). *Down syndrome* (revised pamphlet). (See address below.)

Pueschel, S.M. (Ed.). (1990). *A parent's guide to Down syndrome: Toward a brighter future*. Baltimore, MD: Paul H. Brookes. (Telephone: 1-800-638-3775.)

Stray-Gundersen, K. (1986). *Babies with Down syndrome: A new parent's guide*. Rockville, MD: Woodbine House. [Call Woodbine House at 1-800-843-7323 (outside DC area) or (301) 468-8800 (in DC area).]

National Down Syndrome Society. *This baby needs you even more*. (See address below.)

Organizations

National Down Syndrome Congress
1605 Chantilly Drive, Suite 250
Atlanta, GA 30324
(404) 633-1555
(800) 232-6372 (Toll Free)

National Down Syndrome Society
666 Broadway
Suite 810
New York, NY 10012
(212) 460-9330
(1-800) 221-4602 (Toll Free)

The Arc (formerly the Association for Retarded Citizens of the United States)
500 East Border Street, Suite 300
Arlington, TX 76010
(817) 261-6003; 1-800-433-5255

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For more information contact NICHCY.

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NICHCY

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General Information About

EMOTIONAL DISTURBANCE

Definition

Many terms are used to describe emotional, behavioral, or mental disorders. Currently, students with such conditions are categorized as having a serious emotional disturbance, which is defined under the Individuals with Disabilities Education Act (IDEA), Public Law 101-476, as follows:

"...a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects educational performance--

(A) An inability to learn that cannot be explained by intellectual sensory, or health factors;
(B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
(C) Inappropriate types of behavior or feelings under normal circumstances;
(D) A general pervasive mood of unhappiness or depression; or
(E) A tendency to develop physical symptoms or fears associated with personal or school problems." (*Federal Register, 57*(189), September 29, 1992, p. 44802)

As defined by the IDEA, serious emotional disturbance includes schizophrenia but does not apply to children who are socially maladjusted, unless it is determined that they have a serious emotional disturbance.

It is important to know that the Federal government is currently reviewing the way in which serious emotional disturbance is defined and that the definition may be revised.

Incidence

For the school year 1991-920,400,670 children and youth with a serious emotional disturbance were provided services in the public schools (*Fifteenth Annual Report to Congress*, U.S. Department of Education, 1993).

Characteristics

The causes of emotional disturbance have not been adequately determined. Although various factors such as heredity, brain disorder, diet, stress, and family functioning have been suggested as possible causes, research has not shown any [illegible] these factors to be the direct cause of behavior problems. Some of the characteristics and behaviors seen in children who have emotional disturbances include:

- Hyperactivity (short attention span, impulsiveness);
- Aggression/self-injurious behavior (acting out, fighting);
- Withdrawal (failure to initiate interaction with others, retreat from exchanges or social interaction, excessive fear or anxiety);
- Immaturity (inappropriate crying, temper tantrums, poor coping skills); and
- Learning difficulties (academically performing below grade level).

Children with the most serious emotional disturbances may exhibit distorted thinking, excessive anxiety, bizarre motor acts, and abnormal mood swings and are sometimes identified as children who have a severe psychosis or schizophrenia.

Many children who do not have emotional disturbances may display some of these same behaviors at various times during their development. However, when children have a serious emotional disturbance, these behaviors continue over long periods of time. Their behavior signals that they are not coping with their environment or peers.

Educational Implications

The educational programs for children with a serious emotional disturbance need to include attention to mastering academics, developing social skills, and increasing self-awareness, self-control, and self-esteem. Career education (both vocational and academic) is also a major part of secondary education and should be a part of the transition plan included in every adolescent's Individualized Education Program (IEP).

Behavior modification is one of the most widely used approaches to helping children with serious emotional disturbance. However, there are many other techniques that are also successful and may be used in conjunction with behavior modification. Life Space Intervention and Conflict Resolution are two such techniques.

Students eligible for special education services under the category of serious emotional disturbance may have IEPs that include psychological or counseling services. These are important related services which are available under the law and are to be provided by a qualified social worker, psychologist, guidance counselor, or other qualified personnel.

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There is growing recognition that families, as well as their children, need support, respite care, intensive case management services, and a multi-agency treatment plan. Many communities are working toward providing these wrap-around services, and there are a growing number of agencies and organizations actively involved in establishing support services in the community. Parent support groups are also important, and organizations such as the Federation of Families for Children's Mental Health and the Alliance for the Mentally Ill--Children and Adolescent Network (NAMI CAN) have parent representatives and groups in every state. Both of these organizations are listed under the resources section of this fact sheet.

Other Considerations

Families of children with emotional disturbances may need help in understanding their children's condition and in learning how to work effectively with them. Help is available from psychiatrists, psychologists or other mental health professionals in public or private mental health settings. Children should be provided services based on their individual needs, and all persons who are involved with these children should be aware of the care they are receiving. It is important to coordinate all services between home, school, and therapeutic community with open communication.

Resources

Donner, R. & Fine, G. (1987). *A guide for developing self-help/advocacy groups for parents of children with serious emotional problems.* (Distributed by: CASSP Technical Assistance Center, 2233 Wisconsin Ave., N.W. #215 Washington, D.C. 20007. Phone: (202) 338-1831.)

Friedman, R.M., Duchnowski, A.J. & Henderson, E.L., Eds. (1989). *Advocacy on behalf of children with serious emotional problems.* Springfield, Illinois: Charles C. Thomas. (Telephone: 217-789-8980.)

Gordon, T. (1989). *Discipline that works.* Solona Beach, CA: Effective Training, Inc. (Telephone: (619) 481-8121.)

Jordan, D. (1991). *A guidebook for parents of children with emotional or behavior disorders.* Minneapolis, MN: Pacer Center. (Telephone: (612) 827-2966.)

Kelker, K.A. (1988). *Taking charge: A handbook for parents whose children have emotional handicaps* (2nd ed.). Portland, OR: Portland State University. (Telephone: (503) 725-4040.)

McElroy, E. (Ed.). (1988). *Children and adolescents with mental illness.* Rockville, MD: Woodbine House. [Contact Woodbine House at (301) 468-8800 (in DC area) or 1-800-843-7323 (outside DC area).]

National directory of organizations serving parents of children and youth with emotional and behavioral disorders (2nd ed.). (1988). Portland, OR: Portland State University. (See telephone number above.)

Rubin, J., & Rubin, C. (1989). *When families fight.* New York: Ballantine.

Wood, M.M., & Long, N.J. (1991). *Life space interventions: Talking with children in crisis.* Austin, TX: Pro-Ed. (Telephone: (512) 451-3246.)

Organizations

American Academy of Child and Adolescent Psychiatry
Public Information Office
3615 Wisconsin Ave., NW
Washington, DC 20016
(202) 966-7300

ERIC Clearinghouse on Disabilities and Gifted Education
Council for Exceptional Children
1920 Association Dr.
Reston, VA 22091-1589
(800) 328-0272

Federation of Families for Children's Mental Health
1021 Prince St., 3rd Floor
Alexandria, VA 22314-2971
(703) 684-7710

National Alliance for the Mentally Ill
2101 Wilson Blvd., Suite 302
Arlington, VA 22201
(703) 524-7600; (800) 950-NAMI

National Clearinghouse on Family Support and Children's Mental Health
Portland State University
P.O. Box 751
Portland, OR 97207-0751
(800) 628-1696 between 8 a.m. and noon Pacific Time
(503) 725-4040

National Mental Health Association
1021 Prince Street
Alexandria, VA 22314-2971
(703) 684-7722

For your state CASSP (Children and Adolescent Service System Program) office and State Mental Health Representative for Children, call NICHCY and ask for a *State Resource Sheet* for your state.

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Fact Sheet Number 6 (FS6), 1993

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General Information About
EPILEPSY

Definition

According to the Epilepsy Foundation of America, epilepsy is a physical condition that occurs when there is a sudden, brief change in how the brain works. When brain cells are not working properly, a person's consciousness, movement, or actions may be altered for a short time. These physical changes are called epileptic seizures. Epilepsy is therefore sometimes called a seizure disorder. Epilepsy affects people in all nations and of all races.

Some people can experience a seizure and not have epilepsy. For example, many young children have convulsions from fevers. These febrile convulsions are one type of seizure. Other types of seizures not classified as epilepsy include those caused by an imbalance of body fluids or chemicals or by alcohol or drug withdrawal. A single seizure does not mean that the person has epilepsy.

Incidence

About two million Americans have epilepsy; of the 125,000 new cases that develop each year, up to 50% are in children and adolescents.

Characteristics

Although the symptoms listed below are not necessarily indicators of epilepsy, it is wise to consult a doctor if you or a member of your family experiences one or more of them:

- "Blackouts" or periods of confused memory;
- Episodes of staring or unexplained periods of unresponsiveness;
- Involuntary movement of arms and legs;
- "Fainting spells" with incontinence or followed by excessive fatigue; or
- Odd sounds, distorted perceptions, episodic feelings of fear that cannot be explained.

Seizures can be generalized, meaning that all brain cells are involved. One type of generalized seizure consists of a convulsion with a complete loss of consciousness. Another type looks like a brief period of fixed staring.

Seizures are partial when those brain cells not working properly are limited to one part of the brain. Such partial seizures may cause periods of "automatic behavior" and altered consciousness. This is typified by purposeful- looking behavior, such as buttoning or unbuttoning a shirt. Such behavior, however, is unconscious, may be repetitive, and is usually not recalled.

Educational Implications

Students with epilepsy or seizure disorders are eligible for special education and related services under the Individuals with Disabilities Education Act (IDEA), formerly the Education of the Handicapped Act (Public Law 94-142). Epilepsy is classified as "other health impaired" and an Individualized Education Program (IEP) would be developed to specify appropriate services. Some students may have additional conditions such as learning disabilities along with the seizure disorders.

Seizures may interfere with the child's ability to learn. If the student has the type of seizure characterized by a brief period of fixed staring, he or she may be missing parts of what the teacher is saying. It is important that the teacher observe and document these episodes and report them promptly to parents and to school nurses.

Depending on the type of seizure or how often they occur, some children may need additional assistance to help them keep up with classmates. Assistance can include adaptations in classroom instruction, first aid instruction on seizure management to the student's teachers, and counseling, all of which should be written in the IEP.

It is important that the teachers and school staff be informed about the child's condition, possible effects of medication, and what to do in case a seizure occurs at school. Most parents find that a friendly conversation with the teacher(s) at the beginning of the school year is the best way to handle the situation. Even if a child has seizures that are largely controlled by medication, it is still best to notify the school staff about the condition.

School personnel and the family should work together to monitor the effectiveness of medication as well as any side effects. If a child's physical or intellectual skills seem to change, it is important to tell the doctor. There may also be associated hearing or perception problems caused by the brain changes. Written observations of both the family and school staff will be helpful in discussions with the child's doctor.

Children and youth with epilepsy must also deal with the psychological and social aspects of the condition. These include public misperceptions and fear of seizures, uncertain occurrence, loss of self control during the seizure episode, and compliance with medications. To help children feel more confident about themselves and accept their epilepsy, the school can assist by providing epilepsy education programs for staff and students, including information on seizure recognition and first aid.

Students can benefit the most when both the family and school are working together. There are many materials available for families and teachers so that they can understand how to work most effectively as a team.

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Resources

Epilepsy Foundation of America. (1987). *Epilepsy: You an Your Child, Information for Parents.* Landover, MD: Ep lepsy Foundation of America.

Freeman, J.M., Vining, E., Pillas, D. J. (1993). *Seizures and Epilepsy in Childhood: A Guide for Parents* (rev. ed.). Baltimore, MD: Johns Hopkins University Press. (Telephone: 1-800-537-5487.)

Kobrin, Eileen R. (1991). *Issues and Answers: A Guide for Parents of Teens and Young Adults with Epilepsy.* Landover, MD: Epilepsy Foundation of America. (Telephone: 301-577-0100.)

Reisner, H. (Ed.). (1988). *Children with Epilepsy: A Parent's Guide.* Kensington, MD: Woodbine House. [Telephone: 301-468-8800 (in DC area); 800-843-7323 (outside DC area).]

Organizations

Epilepsy Foundation of America (EFA)
4351 Garden City Drive, Suite 406
Landover, MD 20785
(301) 459-3700; (800) EFA-1000 (Toll Free)
(301) 577-0100, for Publications

National Institute of Neurological Disorders and Stroke (NINDS
National Institutes of Health
Building 31, Room 8A06
9000 Rockville Pike
Bethesda, MD 20892
(301) 496-5751

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General Information About

MENTAL RETARDATION

Definition

People with mental retardation are those who develop at a below average rate and experience difficulty in learning and social adjustment. The regulations for the Individuals with Disabilities Education Act (IDEA), formerly the Education of the Handicapped Act (Public Law 94-142), provide the following technical definition for mental retardation:

> "Mental retardation means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period that adversely affects a child's educational performance."

"General intellectual functioning" typically is measured by an intelligence test. Persons with mental retardation usually score 70 or below on such tests. "Adaptive behavior" refers to a person's adjustment to everyday life. Difficulties may occur in learning, communication, social, academic, vocational, and independent living skills.

Mental retardation is not a disease nor should it be confused with mental illness. Children with mental retardation become adults; they do not remain "eternal children." They do learn, but slowly and with difficulty.

Probably the greatest number of children with mental retardation have chromosome abnormalities. Other biological factors include (but are not limited to): asphyxia (lack of oxygen); blood incompatibilities between the mother and fetus; and maternal infections, such as rubella or herpes. Certain drugs have also been nked to problems in fetal development.

Incidence

Some studies suggest that approximately 1% of the general population has mental retardation (when both intelligence and adaptive behavior measures are used). According to data reported to the U.S. Department of Education by the states, in the 1991-92 school year, 554,247 students ages 6-21 were classified as having mental retardation and were provided services by the public schools. This figure does not include students reported as having multiple handicaps or those in noncategorical special education pre-school programs who may also have mental retardation.

Characteristics

Many authorities agree that people with mental retardation develop in the same way as people without mental retardation, but at a slower rate. Others suggest that persons with mental retardation have difficulties in particular areas of basic thinking and learning such as attention, perception, or memory. Depending on the extent of the impairment—mild, moderate, severe, or profound—individuals with mental retardation will develop differently in academic, social, and vocational skills.

Educational Implications

Persons with mental retardation have the capacity to learn, to develop, and to grow. The great majority of these citizens can become productive and full participants in society.

Appropriate educational services that begin in infancy and continue throughout the developmental period and beyond will enable children with mental retardation to develop to their fullest potential.

As with all education, modifying instruction to meet individual needs is the starting point for successful learning. Throughout their child's education, parents should be an integral part of the planning and teaching team.

In teaching persons with mental retardation, it is important to:

- Use concrete materials that are interesting, age-appropriate, and relevant to the students;
- Present information and instructions in small, sequential steps and review each step frequently;
- Provide prompt and consistent feedback;
- Teach these children, whenever possible, in the same school they would attend if they did not have mental retardation;
- Teach tasks or skills that students will use frequently, in such a way that students can apply the tasks or skills in settings outside of school; and
- Remember that tasks that many people learn without instruction may need to be structured, or broken down into small steps or segments, with each step being carefully taught.

Children and adults with mental retardation need the same basic services that all people need for normal development. These include education, vocational preparation, health services, recreational opportunities, and many more. In addition, many persons with mental retardation need specialized services for special needs. Such services include diagnostic and evaluation centers; special early education opportunities, beginning with infant stimulation programs and continuing through preschool; and educational programs that include age-appropriate activities, functional academics, transition training, and opportunities for independent living and competitive employment to the maximum extent possible.

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Resources

Smith, R. (Ed.). (1993). *Children with mental retardation: A parents' guide.* Rockville, MD: Woodbine House. [Telephone: 800-843-7323 (outside DC area); (301) 468-8800 (in DC area).]

Trainer, M. (1991). *Differences in common: Straight talk on mental retardation, Down syndrome, and life.* Rockville, MD: Woodbine House. (See telephone number above.)

Organizations

The Arc (formerly the Association for Retarded Citizens of the United States)
500 East Border Street, Suite 300
Arlington, TX 76010
(817) 261-6003

American Association on Mental Retardation (AAMR)
1719 Kalorama Road, N.W.
Washington, D.C. 20009
(202) 387-1968; (1-800) 424-3688 (Toll-Free)

National Down Syndrome Congress
1605 Chantilly Drive Suite 250
Atlanta, GA 30324
(400) 633-1555; (1-800) 232-6372 (Toll-Free)

National Down Syndrome Society
666 Broadway, Suite 810
New York, NY 10012
(212) 460-9330; (1-800) 221-4602 (Toll-Free)

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General Information About

LEARNING DISABILITIES

Definition

The regulations for Public Law (P.L.) 101-476, the Individuals with Disabilities Education Act (IDEA), formerly P.L. 94-142, the Education of the Handicapped Act (EHA), define a learning disability as a "disorder in one or more of the basic psychological processes involved in understanding or in using spoken or written language, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell or to do mathematical calculations."

The Federal definition further states that learning disabilities include "such conditions as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia." According to the law, learning disabilities do not include learning problems that are primarily the result of visual, hearing, or motor disabilities; mental retardation; or environmental, cultural, or economic disadvantage. Definitions of learning disabilities also vary among states.

Having a single term to describe this category of children with disabilities reduces some of the confusion, but there are many conflicting theories about what causes learning disabilities and how many there are. The label "learning disabilities" is all-embracing; it describes a syndrome, not a specific child with specific problems. The definition assists in classifying children, not teaching them. Parents and teachers need to concentrate on the individual child. They need to observe both how and how well the child performs, to assess strengths and weaknesses, and develop ways to help each child learn. It is important to remember that there is a high degree of interrelationship and overlapping among the areas of learning. Therefore, children with learning disabilities may exhibit a combination of characteristics.

These problems may mildly, moderately, or severely impair the learning process.

Incidence

Many different estimates of the number of children with learning disabilities have appeared in the literature (ranging from 1% to 30% of the general population). In 1987, the Interagency Committee on Learning Disabilities concluded that 5% to 10% is a reasonable estimate of the percentage of persons affected by learning disabilities. The U.S. Department of Education (1993) reported that more than 4% of all school-aged children received special education services for learning disabilities and that in the 1991-92 school year over 2 million children with learning disabilities were served. Differences in estimates perhaps reflect variations in the definition.

Characteristics

Learning disabilities are characterized by a significant difference in the child's achievement in some areas, as compared to his or her overall intelligence.

Students who have learning disabilities may exhibit a wide range of traits, including problems with reading comprehension, spoken language, writing, or reasoning ability. Hyperactivity, inattention, and perceptual coordination problems may also be associated with learning disabilities. Other traits that may be present include a variety of symptoms, such as uneven and unpredictable test performance, perceptual impairments, motor disorders, and behaviors such as impulsiveness, low tolerance for fustruation, and problems in handling day-to-day social interactions and situations.

Learning disabilities may occur in the following academic areas:

1. Spoken language: Delays, disorders, or discrepancies in listening and speaking;
2. Written language: Difficulties with reading, writing, and spelling;
3. Arithmetic: Difficulty in performing arithmetic functions or in comprehending basic concepts;

4. Reasoning: Difficulty in organizing and integrating thoughts; and
5. Organization skills: Difficulty in organizing all facets of learning.

Educational Implications

Because learning disabilities are manifested in a variety of behavior patterns, the Individual Education Program (IEP) must be designed carefully. A team approach is important for educating the child with a learning disability, beginning with the assessment process and continuing through the development of the IEP. Close collaboration among special class teachers, parents, resource room teachers, regular class teachers, and others will facilitate the overall development of a child with learning disabilities.

Some teachers report that the following strategies have been effective with some students who have learning disabilities:

- Capitalize on the student's strengths;
- Provide high structure and clear expectations;
- Use short sentences and a simple vocabulary;
- Provide opportunities for success in a supportive atmosphere to help build self-esteem;
- Allow flexibility in classroom procedures (e.g., allowing the use of tape recorders for note-taking and test-taking when students have trouble with written language);
- Make use of self-correcting materials, which provide immediate feedback without embarrassment;
- Use computers for drill and practice and teaching word processing;
- Provide positive reinforcement of appropriate social skills at school and home; and
- Recognize that students with learning disabilities can greatly benefit from the gift of time to grow and mature.

Resources

Journal of Learning Disabilities. Available from Pro-Ed, 8700 Shoal Creek Blvd., Austin TX 78758. Telephone: (512) 451-3246.)

Silver, L. (1991). *The misunderstood child: A guide for parents of children with learning disabilities* (2nd ed.). New York, NY: McGraw Hill Book Co. (Available from McGraw Hill Retail, 13311 Monterey Lane, Blue Ridge Summit, PA 17294. Telephone: (717) 794-5461.)

Smith, S. (1981). *No easy answers.* New York, NY: Bantam Books. (Available from Bantam, 2451 South Wolf Rd., Des Plaines, IL 60018. Telephone: 1-
223-6834.)

Organizations

Council for Learning Disabilities (CLD)
P.O. Box 40303
Overland Park, KS 66204
(913) 492-8755

Division of Learning Disabilities
Council for Exceptional Children
1920 Association Dr.
Reston, VA 22091-1589
(703) 620-3660

Learning Disabilities Assn. of America (LDA)
4156 Library Road
Pittsburgh, PA 15234
(412) 341-1515
(412) 341-8077

National Center for Learning Disabilities
99 Park Avenue
New York, NY 10016
(212) 687-7211

National Network of Learning Disabled Adults (NNLDA)
P.O. Box 32611
Phoenix, AZ 85064
(602) 941-5112

Orton Dyslexia Society
Chester Building, Suite 382
8600 LaSalle Road
Baltimore, MD 21286-2044
(410) 296-0232
(800) 222-3123 (Toll Free)

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General Information About

PHYSICAL DISABILITIES AND SPECIAL HEALTH PROBLEMS

Definition

Orthopedic or physical disabilities describe medical or structural conditions which may be serious enough to disrupt the child's development and require special attention in school. Typical examples of orthopedic or physical problems include disabilities present at birth (such as missing limbs, spina bifida, etc.), as well as physical problems resulting from other causes (such as contractures caused by burns or fractures, etc.). In addition, neurological problems, such as cerebral palsy, may be included in this category.

Health impairments may result in limited strength, vitality and/or alertness. Asthma, cardiac conditions, sickle cell anemia, epilepsy, and leukemia are examples of health impairments that could interfere with a child's education.

Incidence

One half of one percent (.5%) is the figure usually cited in estimates of school aged children with physical or health impairments. Cerebral palsy accounts for a large part of this percentage, followed by spina bifida.

Characteristics

Physical disabilities can produce a variety of characteristics. Children may experience a wide range of restrictions on their activity, from little or none to a complete restructuring of daily life. The most severly affected children may require intensive medical and educational help.

Physical problems may interfere with children's motor functioning, communication, learning skills, or social development.

Educational Implications

The contributions of such related services as physical, occupational, and speech and language therapy are often central to the education of children with physical disabilities. The greatest progress is achieved when therapy suggestions are consistently applied in the child's home as well as in school. This carryover strengthens appropriate feeding, positioning, and language stimulation patterns.

Architectural factors must be considered. Section 504 of the Rehabilitation Act of 1973 requires that programs receiving Federal funds make their programs accesible. This could mean structural changes (for example, adding elevators or ramps) or schedule or location changes (for example, offering a course on the ground floor).

Sometimes the nature of the child's disability requires changes in school equipment or curriculum. In the same way a student's placement should be the least restrictive one appropriate for him or her, the day-to-day school pattern also should be as "normal" as possible.

Physical disabilities can have profound effects on children's emotional and social development. To promote growth, parents and teachers should avoid overprotection and encourage children to take risks within limits of safety and health. Teachers and classmates should also understand that, although children with physical disabilities and health impairments may be physically disabled, they are more like their classmates than different from them.

Technology holds great promise for making the life of a child with a disability more "normal." Computerized devices, for example, can help nonvocal, severely physically involved children communicate, perhaps for the first time.

Students who require recurring or long-term hospital care for their condition may need special services such as tutoring or homebound instruction to keep up with their class. Depending upon the nature and severity of the condition, counseling for the entire family may be helpful.

References

Batshaw, M.L. (1991). *Your child has a disability: A complete sourcebook of daily and medical care.* Boston: Little, Brown. (Telephone: 1-800-759-0190.)

Finston, P. (1990). *Parenting plus: Raising children with special health care needs.* New York: Dutton. (Telephone: 1-800-253-6476.)

Hochstadt, N.J., & Yost, D.M. (Eds.). (1991). *The medically complex child: The transition to home care.* New York: Harwood Academic. (Telephone: (212) 206-8900.)

Krementz, J. (1992). *How it feels to live with a physical disability.* New York: Simon & Schuster. (Telephone: 1-800-374-1200.)

Larson, G. (Ed.). (1988). *Managing the school-age child with a chronic health condition: A practical guide for schools, families, and organizations.* Wayzata, MN: DCI Publishing. (Contact Sunrise River Press at (612) 583-3239.)

Larson, G., & Kahn, J.A. (1991). *Special needs - special solutions: How to get quality care for a child with special health needs.* St. Paul, MN: Lifeline Press. (Telephone: (612) 659-9114.)

Maddox, S. (in press). *Spinal network: The total resource for the wheelchair community* (2nd ed.). Boulder, CO: Spinal Network. (Telephone: 1-800-338-5412.)

Moore, C. (1990). *Reader's guide for parents of children with mental, physical, or emotional disabilities.* Rockville, MD: Woodbine House. [Telephone: 1-800-843-7323 (outside DC area); (301) 468-8800 (in DC area).]

Project School Care, Children's Hospital. (1992). *Working toward a balance in our lives: A booklet for families of children with disabilities and special health care needs.* Boston, MA: Author. (Telephone: (617) 735-6714.)

Thompson, C.E. (1986). *Raising a handicapped child: A helpful guide for parents of the physically disabled.* New York: Ballantine Books. (Available from the Special Needs Project, telephone: (805) 565-1914; for orders, 1-800-333-6867.)

Resources

Accent on Information
P.O. Box 700
Gillum Road and High Drive
Bloomington, IN 61701
(309) 378-2961

American Paralysis Association
500 Morris Avenue
Springfield, NJ 07081
800-225-0292; 800-526-3456 (Hotline)

Cancer Information and Counseling Line
AMC Cancer Research Center
1600 Pierce Street
Denver, CO 80214
1-800-525-3777; (303) 233-6501

Candlelighters Childhood Cancer Foundation
7910 Woodmont Avenue #460
Bethesda, MD 20814-3015
1-800-366-2223; (301) 657-8401

Council for Exceptional Children
1920 Association Drive
Reston, VA 22091
(703) 620-3660

Epilepsy Foundation of America
4351 Garden City Drive, Suite 406
Landover, MD 20785
1-800-332-1000; (301) 459-3700

March of Dimes Birth Defects Foundation
P.O. Box 2000, 1275 Mamaroneck Avenue
White Plains, NY 10605
(914) 428-7100

National Easter Seal Society
230 West Monroe Street, Suite 1800
Chicago, IL 60606
(312) 726-6200; (800) 221-6827

National Library Service for the Blind and Physically Handicapped
Library of Congress
Washington, DC 20542
(202) 707-9275

National Rehabilitation Information Center (NARIC)
8455 Colesville Rd., Suite 935
Silver Spring, MD 20910
1-800-227-0216; (301) 588-9284

United Cerebral Palsy Association, Inc.
1522 K Street, N.W., Suite 1112
Washington, DC 20005
(202) 842-1266, (800) 822-5827

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General Information About

SEVERE AND/OR MULTIPLE DISABILITIES

Definition

People with severe disabilities are those who traditionally have been labeled as having severe or profound mental retardation. These people require ongoing extensive support in more than one major life activity in order to participate in integrated community settings and enjoy the quality of life available to people with fewer or no disabilities; they frequently have additional disabilities, including movement difficulties, sensory losses and behavior problems.

Incidence

In the 1991-92 school year, the states reported to the U.S. Department of Education that they were providing services to 98,402 students with multiple disabilities. This number represents .14 percent of the school enrollment.

Characteristics

People with severe or multiple disabilities may exhibit a wide range of characteristics, depending on the combination and severity of disabilities, and the person's age. There are, however, some traits they may share, including:

- Limited speech or communication;
- Difficulty in basic physical mobility;
- Tendency to forget skills through disuse;
- Trouble generalizing skills from one situation to another; and
- A need for support in major life activities, e.g., domestic, leisure, community use, vocational.

Medical Implications

A variety of medical problems may accompany severe disabilities. Examples include seizures, cerebral palsy, sensory loss, hydrocephalus, and scoliosis. These conditions should be considered when establishing services. A multidisciplinary team consisting of the student's parents, educational specialists and medical specialists in the areas in which the individual demonstrates problems should work together to plan and coordinate necessary services.

Educational Implications

In the past, students with severe and/or multiple disabilities were routinely excluded from public schools. Since the implementation of Public Law 94-142, (The Education of the Handicapped Act, now called the Individuals with Disabilities Education Act, or IDEA), public schools now serve large numbers of students with severe and/or multiple disabilities. Educational programming is likely to begin as early as infancy. At that time, as well as later on, the primary focus is upon increasing the child's independence.

In order to be effective, educational programs need to incorporate a variety of components to meet the considerable needs of individuals with severe and/or multiple disabilities. Programs should access needs in four major areas: domestic, leisure/recreational, community and vocational. These assessments enable the identification of functional objectives (objectives which will result in the learner's increased skill and independence in dealing with the routine activities of his/her life). Instruction should include: Expression of choice; communication; functional skill development; and age-appropriate social skills training.

Related services are of great importance, and the multidisciplinary approach is crucial. Appropriate people such as speech and language therapists, physical and occupational therapists, and medical specialists need to work closely with classroom teachers and parents. Because of problems with skill generalization, related services are best offered during the natural routine in the school and community rather than removing a student from class for isolated therapy.

Frequently, classroom arrangements must take into consideration students' needs for medications, special diets, or special equipment. Adaptive aids and equipment enable students to increase their range of functioning. For example, in recent years computers have become effective communication devices. Other aides include: wheelchairs, typewriters, headsticks (head gear), clamps, modified handles on cups and silverware, and communication boards. Computerized communication equipment and specially built vocational equipment also play important roles in adapting working environments for people with serious movement limitations.

Integration with nondisabled peers is another important component of the educational setting. Attending the same school and participating in the same activities as their nondisabled peers is crucial to the development of social skills and friendships for people with severe disabilities. Integration also benefits nondisabled peers and professionals through positive attitude change.

Beginning as early as the elementary school years, community-based instruction is an important characteristic of educational programming. In order to increase the student's ability to generalize (transfer) skills to appropriate situations, this type of instruction takes place in the actual setting where the skills will be used. As students grow older, increasing time is spent in the community; high school students may spend as much as 90 percent of their day there. Programs should draw on existing adult services in the community, including group homes, vocational programs and recreational settings.

In light of the current Vocational Rehabilitation Act and the practice of supported employment, schools are now using school-to-work transition planning and working toward job placement in integrated, competitive settings rather than sheltered employment and day activity centers.

Resources

Callahan, C. (1990). *Since Owen: A parent to parent guide for care of the disabled child.* Baltimore, MD: John Hopkins University Press. (Telephone: 1-800-537-5487.)

Falvey, M.A. (1989). *Community-based curriculum: Instructional strategies for students with severe handicaps* (2nd ed.). Baltimore, MD: Paul H. Brookes. (Telephone: 1-800-638-3775.)

Orelove, F. & Sobsey, D. (1991). *Educating children with multiple disabilities: A transdisciplinary approach* (2nd ed.). Baltimore, MD: Paul H. Brookes.

Snell, M.E. (Ed.) (1993). *Systematic instruction of persons with severe disabilities* (4th ed.) Columbus, OH: Merrill. (Available from Macmillan, 1-800-228-7854.)

Wehman, P., Moon, M.S., Everson, J.M., Wood, W. & Barcus, J.M. (1988). *Transition from school to work: New challenges for youth with severe disabilities.* Baltimore, MD: Paul H. Brookes.

Organizations

Association for Persons with Severe Handicaps (TASH)
11201 Greenwood Ave. North
Seattle, WA 98133
206-361-8770

National Rehabilitation Information Center (NARIC)
8455 Colesville Road, Suite 935
Silver Spring, MD 20910-3319
301-588-9284
800-346-2742 (Toll Free)

The Arc (formerly the Association for Retarded Citizens of the United States)
500 East Border Street, Suite 300
Arlington, TX 76010
(817) 261-6003

United Cerebral Palsy Associations, Inc.
1522 K Street N.W., Suite 1112
Washington, DC 20005
800-872-5827 (Toll Free); (202) 842-1266

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General Information About

SPEECH AND LANGUAGE DISORDERS

Definition

Speech and language disorders refer to problems in communication and related areas such as oral motor function. These delays and disorders range from simple sound substitutions to the inability to understand or use language or use the oral-motor mechanism for functional speech and feeding. Some causes of speech and language disorders include hearing loss, neurological disorders, brain injury, mental retardation, drug abuse, physical impairments such as cleft lip or palate, and vocal abuse or misuse. Frequently, however, the cause is unknown.

Incidence

One quarter of the students served in the public schools' special education programs (over 1 million children in the 1991-92 school year) were categorized as speech or language impaired. This estimate does not include children who have speech/language problems secondary to other conditions such as deafness. Language disorders may be related to other disabilities such as mental retardation, autism, or cerebral palsy. It is estimated that communication disorders (including speech, language, and hearing disorders) affect one of every 10 people in the United States.

Characteristics

A child's communication is considered delayed when the child is noticeably behind his or her peers in the acquisition of speech and/or language skills. Sometimes a child will have greater receptive (understanding) than expressive (speaking) language skills, but this is not always the case.

Speech disorders refer to difficulties producing speech sounds or problems with voice quality. They might be characterized by an interruption in the flow or rhythm of speech, such as stuttering, which is called dysfluency. Speech disorders may be problems with the way sounds are formed, called articulation or phonological disorders, or they may be difficulties with the pitch, volume, or quality of the voice. There may be a combination of several problems. People with speech disorders have trouble using some speech sounds, which can also be a symptom of a delay. They may say "see" when they mean "ski" or they may have trouble using other sounds like "l" or "r". Listeners may have trouble understanding what someone with a speech disorder is trying to say. People with voice disorders may have trouble with the way their voices sound.

A language disorder is an impairment in the ability to understand and/or use words in context, both verbally and nonverbally. Some characteristics of language disorders include improper use of words and their meanings, inability to express ideas, inappropriate grammatical patterns, reduced vocabulary, and inability to follow directions. One or a combination of these characteristics may occur in children who are affected by language learning disabilities or developmental language delay. Children may hear or see a word but not be able to understand its meaning. They may have trouble getting others to understand what they are trying to communicate.

Educational Implications

Because all communication disorders carry the potential to isolate individuals from their social and educational surroundings, it is essential to find appropriate timely intervention. While many speech and language patterns can be called "baby talk" and are part of a young child's normal development, they can become problems if they are not outgrown as expected. In this way an initial delay in speech and language or an initial speech pattern can become a disorder which can cause difficulties in learning. Because of the way the brain develops, it is easier to learn language and communication skills before the age of 5. When children have muscular disorders, hearing problems or developmental delays, their acquisition of speech, language, and related skills is often affected.

Speech-language pathologists assist children who have communication disorders in various ways. They provide individual therapy for the child; consult with the child's teacher about the most effective ways to facilitate the child's communication in the class setting; and work closely with the family to develop goals and techniques for effective therapy in class and at home. Technology can help children whose physical conditions make communication difficult. The use of electronic communication systems allow nonspeaking people and people with severe physical disabilities to engage in the give and take of shared thought.

Vocabulary and concept growth continues during the years children are in school. Reading and writing are taught and, as students get older, the understanding and use of language becomes more complex. Communication skills are at the heart of the education experience. Speech and/or language therapy may continue throughout a student's school year either in the form of direct therapy or on a consultant basis. The speech-language pathologist may assist vocational teachers and counselors in establishing communication goals related to the work experiences of students and suggest strategies that are effective for the important transition from school to employment and adult life.

Communication has many components. All serve to increase the way people learn about the world around them, utilize knowledge and skills, and interact with colleagues, family, and friends.

Resources

Bernthal, J.E. & Bankson, N.W. (1993). *Articulation and phonological disorders* (3rd ed). Englewood Cliffs, NJ: Prentice Hall. (Telephone: 1-800-947-7700.)

Beukelman, D.R., & Mirenda, P. (1992). *Augmentative and alternative communication: Management of severe communication disorders in children and adults*. Baltimore, MD: Paul H. Brookes. (Telephone: 1-800-638-3775.)

Shames, G.H., & Wiig, E.H. (1990). *Human communication disorders: An introduction* (3rd ed.). Columbus, OH: Merrill. (Contact Macmillan Publishing at 1-800-257-5755.)

Organizations

Alliance for Technology Access
1128 Solano Avenue
Albany, CA 94706
(510) 528-0747

Cleft Palate Foundation
1218 Grandview Ave.
University of Pittsburgh
Pittsburgh, PA 15211
412-481-1376; 800-242-5338; 800-243-5338 (in PA)

American Speech-Language-Hearing Association (ASHA)
10801 Rockville Pike
Rockville, MD 20852
301-897-5700 (V/TT); 800-638-8255

Learning Disabilities Association of America (LDA)
4156 Library Road
Pittsburgh, PA 15234
412-341-1515; 412-341-8077

Division for Children with Communication Disorders
c/o Council for Exceptional Children (CEC)
1920 Association Drive
Reston, VA 22091-1589
703-620-3660

National Easter Seal Society
230 West Monroe Street, Suite 1800
Chicago, IL 60606
312-726-6200; 312-726-4258 (TT)
(800) 221-6827 (For information about services for children and youth.)

Scottish Rite Foundation
Southern Jurisdiction, U.S.A., Inc.
1733 Sixteenth Street, N.W.
Washington, DC 20009-3199
202-232-3579

Trace Research and Development Center
University of Wisconsin - Madison
S-151 Waisman Center
Madison, WI 53705-2280
608-262-6966; 608-263-5408 (TT)

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General Information About

SPINA BIFIDA

Definition

Spina Bifida means cleft spine, which is an incomplete closure in the spinal column. In general, the three types of spina bifida (from mild to severe) are:

1. **Spina Bifida Occulta:** There is an opening in one or more of the vertebrae (bones) of the spinal column without apparent damage to the spinal cord.

2. **Meningocele:** The meninges, or protective covering around the spinal cord, has pushed out through the opening in the vertebrae in a sac called the "meningocele." However, the spinal cord remains intact. This form can be repaired with little or no damage to the nerve pathways.

3. **Myelomeningocele:** This is the most severe form of spina bifida, in which a portion of the spinal cord itself protrudes through the back. In some cases, sacs are covered with skin; in others, tissue and nerves are exposed. Generally, people use the terms "spina bifida" and "myelomeningocele" interchangeably.

Incidence

Approximately 40% of all Americans may have spina bifida occulta, but because they experience little or no symptoms, very few of them ever know that they have it. The other two types of spina bifida, meningocele and myelomeningocele, are known collectively as "spina bifida manifesta," and occur in approximately one out of every thousand births. Of these infants born with "spina bifida manifesta," about 4% have the meningocele form, while about 96% have myelomeningocele form.

Characteristics

The effects of myelomeningocele, the most serious form of spina bifida, may include muscle weakness or paralysis below the area of the spine where the incomplete closure (or cleft) occurs, loss of sensation below the cleft, and loss of bowel and bladder control. In addition, fluid may build up and cause an accumulation of fluid in the brain (a condition known as hydrocephalus). A large percentage (70%-90%) of children born with myelomeningocele have hydrocephalus. Hydrocephalus is controlled by a surgical procedure called "shunting," which relieves the fluid buildup in the brain. If a drain (shunt) is not implanted, the pressure buildup can cause brain damage, seizures, or blindness. Hydrocephalus may occur without spina bifida, but the two conditions often occur together.

Educational Implications

Although spina bifida is relatively common, until recently most children born with a myelomeningocele died shortly after birth. Now that surgery to drain spinal fluid and protect children against hydrocephalus can be performed in the first 48 hours of life, children with myelomeningocele are much more likely to live. Quite often, however, they must have a series of operations throughout their childhood. School programs should be flexible to accommodate these special needs.

Many children with myelomeningocele need training to learn to manage their bowel and bladder functions. Some require catheterization, or the insertion of a tube to permit passage of urine.

The courts have held that clean, intermittent catheterization is necessary to help the child benefit from and have access to special education and related services. A successful bladder management program can be incorporated into the regular school day. Many children learn to catheterize themselves at a very early age.

In some cases, children with spina bifida who also have a history of hydrocephalus experience learning problems. They may have difficulty with paying attention, expressing or understanding language, and grasping reading and math. Early intervention with children who experience learning problems can help considerably to prepare them for school.

Mainstreaming, or successful integration of a child with spina bifida into a school attended by nondisabled young people, sometimes requires changes in school equipment or the curriculum. Although student placement should be in the least restrictive environment the day-to-day school pattern also should be as "normal" as possible. In adapting the school setting for the child with spina bifida, architectural factors should be considered. Section 504 of the Rehabilitation Act of 1973 requires that programs receiving federal funds make their facilities accessible. This can occur through structural changes (for example, adding elevators or ramps) or through schedule or location changes (for example, offering a course on the ground floor).

Children with myelomeningocele need to learn mobility skills, and often require the aid of crutches, braces, or wheelchairs. It is important that all members of the school team and the parents understand the child's physical capabilities and limitations. Physical disabilities like spina bifida can have profound effects on a child's emotional and social development. To promote personal growth, families and teachers should encourage children, within the limits of safety and health, to be independent and to participate in activities with their nondisabled classmates.

Resources

Bloom, B.A., & Seljeskog, E.S. (1988). *A parent's guide to spina bifida*. Minneapolis, MN: University of Minnesota Press. (Telephone: 1-800-388-3863.)

National Institute of Neurological and Communicative Disorders and Stroke. (1986). *Spina bifida: Hope through research*. (Available from the Spina Bifida Association of America. See address under organizations.)

Williamson, G. (Ed.). (1987). *Children with spina bifida: Early intervention and preschool programming*. Baltimore: Paul H. Brookes. (Available from Paul H. Brookes Publishing Co. at 1-800-638-3775.)

Organizations

Spina Bifida Association of America
4590 MacArthur Boulevard, Suite 250
Washington, D.C. 20007
(202) 944-3285
(1-800) 621-3141 (Toll Free)

March of Dimes Birth Defects Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605
(914) 428-7100

National Center for Education in Maternal and Child Health
8201 Greensboro Dr., Suite 600
McLean, VA 22102
(703) 821-8955, Ext. 254 or 265

National Easter Seal Society
230 West Monroe Street, Suite 1800
Chicago, IL 60606
(312) 726-6200
(1-800) 221-6827 (Toll Free)

National Rehabilitation Information Center (NARIC)
8455 Colesville Road, Suite 935
Silver Spring, MD 20910-3319
(301) 588-9284
(1-800) 227-0216 (Toll Free)

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*SpecialNet User Name: NICHCY ** SCAN User Name: NICHCY*

General Information About
TRAUMATIC BRAIN INJURY

Definition

The regulations for Public Law 101-476, the Individuals with Disabilities Education Act (IDEA), formerly the Education of the Handicapped Act, now include Traumatic Brain Injury (TBI) as a separate disability category. While children with TBI have always been eligible for special education and related services, it should be easier for them under this new category to receive the services to which they are entitled.

Traumatic Brain Injury (TBI) is defined within the IDEA as an acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects a child's educational performance. The term applies to open and closed head injuries resulting in impairments in one or more areas, such as: cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual, and motor abilities; psychosocial behavior; physical functions; information processing; and speech. The term does not apply to brain injuries that are congenital or degenerative, or brain injuries induced by birth trauma. *(U.S. Federal Register, 57*(189), September 29, 1992, p.44802)

Incidence

TBI is the leading cause of death and disability in children and adolescents in the United States. The most frequent causes of TBI are related to motor vehicle crashes, falls, sports, and abuse/assault. More than one million children sustain head injuries annually; approximately 165,000 require hospitalization. However, many students with mild brain injury may never see a health care professional at the time of the accident.

Characteristics

The National Head Injury Foundation calls TBI "the silent epidemic," because many children have no visible impairments after a head injury. Symptoms can vary greatly depending upon the extent and location of the brain injury. However, impairments in one or more areas (such as cognitive functioning, physical abilities, communication, or social/behavioral disruption) are common. These impairments may be either temporary or permanent in nature and may cause partial or total functional disability as well as psychosocial maladjustment. Children who sustain TBI may experience a complex array of problems, including:

- *Physical impairments:* Speech, vision, hearing, and other sensory impairment; headaches; lack of fine motor coordination; spasticity of muscles; paresis or paralysis of one or both sides; seizure disorders; and balance and other gait impairments.
- *Cognitive impairments:* Short- and long-term memory deficits, impaired concentration, slowness of thinking, and limited attention span, as well as impairments of perception, communication, reading and writing skills, planning, sequencing, and judgment.
- *Psychosocial, behavioral, or emotional impairments:* Fatigue, mood swings, denial, self-centeredness, anxiety, depression, lowered self-esteem, sexual dysfunction, restlessness, lack of motivation, inability to self-monitor, difficulty with emotional control, inability to cope, agitation, excessive laughing or crying, and difficulty relating to others.

Any or all of the above impairments may occur to different degrees. The nature of the injury and its attendant problems can range from mild to severe, and the course of recovery is very difficult to predict for any given student. It is important to note that, with early and ongoing therapeutic intervention, the severity of these symptoms may decrease, but in varying degrees.

Educational Implications

Despite the high incidence of TBI, many medical and education professionals are unaware of the consequences of childhood head injury. Students with TBI are too often inappropriately classified as having learning disabilities, emotional disturbance, or mental retardation. As a result, the needed educational and related services may not be provided within the special education program. The designation of TBI as a separate category of disability signals that schools should provide children and youth with access to and funding for neuro-psychological, speech and language, educational, and other evaluations necessary to provide the information needed for the development of an appropriate individualized education program (IEP).

While the majority of children with TBI return to school, their educational and emotional needs are likely to be very different than they were prior to the injury. Although children may seem to function much like children born with other handicapping conditions, it is important to recognize that the sudden onset of a severe disability resulting from trauma is very different. Children with brain injuries can often remember how they were before the trauma, which can result in a constellation of emotional and psychosocial problems not usually present in children with congenital disabilities. Further, the trauma impacts family, friends, and professionals who recall what the child was like prior to injury and who have difficulty in shifting and adjusting goals and expectations.

Therefore, careful planning for school re-entry (including establishing linkages between the trauma center/rehabilitation hospital and the special education team at the school) is extremely important in meeting the needs of the child. It will be important to determine whether the child needs to relearn material previously known. Supervision may be needed (i.e., between the classroom and restroom) as the child may have difficulty with orientation. Teachers should also be aware that, because the child's short-term memory may be impaired, what appears to have been learned may be forgotten later in the day. To work constructively with students with TBI, educators may need to:

- Provide repetition and consistency;
- Demonstrate new tasks, state instructions, and provide examples to illustrate ideas and concepts;
- Avoid figurative language;
- Reinforce lengthening periods of attention to appropriate tasks;
- Probe skill acquisition frequently and provide repeated practice;
- Teach compensatory strategies for increasing memory;
- Be prepared for students' reduced stamina, and provide rest breaks as needed; and
- Keep the environment as distraction-free as possible.

Initially, it may be important for teachers to gauge whether the child can follow one-step instructions well before challenging the child with a sequence of two or more directions. Often attention is focused on the child's disabilities after the injury, which reduces self-esteem; therefore, it is important to provide opportunities for success and to maximize the child's strengths.

Resources

Begali, V. (1992). *Head injury in children and adolescents: A resource and review for school and allied professionals* (2nd ed.). Brandon, VT: Clinical Psychology Publishing Company, Inc.

Cutler, B.C. (1993). *You, your child, and "special" education: A guide to making systems work.* Baltimore, MD: Paul H. Brookes Publishing Co. (Telephone: 1-800-638-3775.)

Gerring, P.J., & Carney, J.M. (1992). *Head trauma: Strategies for educational reintegration.* San Diego, CA: Singular Publishing Group, Inc. (Telephone: 1-800-521-8545.)

Lash, M. (1992). *When your child goes to school after an injury.* Boston, MA: Exceptional Parent Press.

National Rehabilitation Information Center. (1992). *Traumatic brain injury: A NARIC resource guide for people with TBI and their families.* Silver Spring, MD:Author. (Telephone: 1-800-227-0216.)

Savage, R. (1988). *An educator's manual: What educators need to know about students with TBI.* Washington, DC: National Head Injury Foundation, Inc. (See address below.)

Tucker, B.F., & Colson, S.E. (1992). Traumatic brain injury: An overview of school re-entry. *Intervention in School and Clinic,* 27(4), 198-206.

Organizations

National Head Injury Foundation
1776 Massachusetts Avenue, NW, Suite 100
Washington, DC 20036
800-444-6443 (Family Helpline); 202-296-6443

Epilepsy Foundation of America
4351 Garden City Drive, Suite 406
Landover, MD 20785
301-459-3700; (800) 332-1000

THINK FIRST Foundation
22 South Washington St.
Park Ridge, IL 60068
(708) 692-2740

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General Information About

VISUAL IMPAIRMENTS

Definition

The terms partially sighted, low vision, legally blind, and totally blind are used in the educational context to describe students with visual impairments. These terms are defined as follows:

- "Partially sighted" indicates some type of visual problem has resulted in a need for special education;
- "Low vision" generally refers to a severe visual impairment, not necessarily limited to distance vision. Low vision applies to all individuals with sight who are unable to read the newspaper at a normal viewing distance, even with the aid of eyeglasses or contact lenses. They use a combination of vision and other senses to learn, although they may require adaptations in lighting, the size of print, and, sometimes, braille;
- "Legally blind" indicates that a person has less than 20/200 vision in the better eye or a very limited field of vision (20 degrees at its widest point); and
- Totally blind students, who learn via braille or other non-visual media.

Visual impairment is the consequence of a functional loss of vision, rather than the eye disorder itself. Eye disorders which can lead to visual impairments can include retinal degeneration, albinism, cataracts, glaucoma, muscular problems that result in visual disturbances, corneal disorders, diabetic retinopathy, congenital disorders, and infection.

Incidence

The rate at which visual impairments occur in individuals under the age of 18 is 12.2 per 1,000. Severe visual impairments (legally or totally blind) occur at a rate of .06 per 1,000.

Characteristics

The effect of visual problems on a child's development depends on the severity, type of loss, age at which the condition appears, and overall functioning level of the child. Many children who have multiple disabilities may also have visual impairments resulting in motor, cognitive, and/or social developmental delays.

A young child with visual impairments has little reason to explore interesting objects in the environment and, thus, may miss opportunities to have experiences and to learn. This lack of exploration may continue until learning becomes motivating or until intervention begins.

Because the child cannot see parents or peers, he or she may be unable to imitate social behavior or understand nonverbal cues. Visual disabilities can create obstacles to a growing child's independence.

Educational Implications

Children with visual impairments should be assessed early to benefit from early intervention programs, when applicable. Technology in the form of computers and low-vision optical and video aids enable many partially sighted, low vision, and blind children to participate in regular class activities. Large print materials, books on tape, and braille books are available.

Students with visual impairments may need additional help with special equipment and modifications in the regular curriculum to emphasize listening skills, communication, orientation and mobility, vocation/career options, and daily living skills. Students with low vision or those who are legally blind may need help in using their residual vision more efficiently and in working with special aids and materials. Students who have visual impairments combined with other types of disabilities have a greater need for an interdisciplinary approach and may require greater emphasis on self care and daily living skills.

Resources

American Foundation for the Blind. (1993). *AFB directory of services for blind and visually impaired persons in the United States and Canada* (24th ed.). New York, NY: Author.

Curran, E.P. (1988). *Just enough to know better (A braille primer).* Boston, MA: National Braille Press.

Dodson-Burk, B., & Hill, E.W. (1989). *An orientation and mobility primer for families and young children* (Item 1576). New York, NY: American Foundation for the Blind.

Ferrell, K.A. (1985). *Reach out and teach: Materials for parents of visually handicapped and multi-handicapped young children* (Item 2084). New York: American Foundation for the Blind.

Hazekamp, J., & Huebner, K.M. (1989). *Program planning and evaluation for blind and visually impaired students: National guidelines for educational excellence* (Item 155x). New York, NY: American Foundation for the Blind.

Holbrook, M.C. (Ed.). (in press). *Children with visual impairments: A parents' guide.* Rockville, MD: Woodbine. [Telephone: 1-800-843-7323 (outside DC area); (301) 468-8800 (in DC area).]

Huebner, K.M.,& Swallow, R.M. (1987). *How to thrive, not just survive: A guide to developing independent life skills for blind and visually impaired children and youth* (Item 1487). New York, NY: American Foundation for the Blind.

Scott, E., Jan, J., & Freeman, R. (1985). *Can't your child see?* (2nd ed.). Austin, TX: Pro-Ed. [Available from Pro-Ed, at (512) 451-3246.]

Organizations

American Council of the Blind Parents
c/o American Council of the Blind
1515 15th St. N.W., Suite 720
Washington, D.C. 20005
(202) 467-5081; (1-800) 424-8666

American Foundation for the Blind
15 West 16th Street
New York, NY 10011
(212) 620-2000; (1-800) AFBLIND (Toll Free Hotline)
For publications, call: (718) 852-9873

Blind Children's Center
4120 Marathon Street
Los Angeles, CA 90029-0159
(213) 664-2153; (1-800) 222-3566

Division for the Visually Handicapped
c/o Council for Exceptional Children
1920 Association Drive
Reston, VA 22091-1589
(703) 620-3660

National Association for Parents of the Visually Impaired, Inc.
P.O. Box 317
Watertown, MA 02272
(817) 972-7441

National Association for Visually Handicapped
22 West 21st Street, 6th Floor
New York, NY 10010
(212) 889-3141

National Braille Association, Inc. (NBA)
1290 University Avenue
Rochester, NY 14607
(716) 473-0900

National Braille Press
88 St. Stephen Street
Boston, MA 02115
(617) 266-6160; (1-800) 548-7323

National Eye Institute
National Institutes of Health
U.S. Department of Health & Human Services
Building 31, Room 6A32
Bethesda, MD 20892
(301) 496-5248

National Federation of the Blind, Parents Division
c/o National Federation of the Blind
1800 Johnson Street
Baltimore, MD 21230
(410) 659-9314

National Library Services for the Blind and Physically Handicapped
Library of Congress
1291 Taylor Street, N.W.
Washington, D.C. 20542
(202) 707-5100; (1-800) 424-8567

National Retinitis Pigmentosa Foundation
1401 Mt. Royal Avenue, Fourth Floor
Baltimore, MD 21217
(410) 225-9400; (410) 225-9409 (TT)
(1-800) 683-5555 (Toll Free)

National Society to Prevent Blindness
500 E. Remington Road
Schaumburg, IL 60173
(708) 843-2020; (1-800) 221-3004 (Toll Free)

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UPDATE 12/93

The Enterprise Zone-Preschool Inclusion Project

A Training and Resource Manual for Inclusion in Childcare

Book 3: Mentoring Component

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A helpful tool for Early Care & Educational Professionals

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The Enterprise Zone-Preschool Inclusion Project

A Training and Resource Manual for Inclusion in Childcare

University of Miami

School of Medicine
Mailman Center for Child Development
Miami, Florida

Susan Gold, Ed.D., Principal Investigator

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The Enterprise Zone-Preschool Inclusion Project

Book 3
Mentoring Component

Book 3: MENTORING COMPONENT

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The Enterprise Zone-Preschool Inclusion Project

Mentoring Component Overview

Mentoring Component

Introduction

The third component of the Enterprise Zone – Preschool Inclusion Project (EZ-PIP) was to offer mentors to participating childcare staff. We adapted *The Early Childhood Mentoring Curriculum: A Handbook for Mentors* (Bellm, Whitebook, & Hnatiuk, 1997) for use in our mentor training component. Information regarding ordering the curriculum is available at the end of this section. Additionally, we incorporated information about including children with special needs and provided Mentor Handbooks to assist in the process of developing a successful mentoring model.

The training that we provided in EZ-PIP and the technical assistance offered through the Special Instruction Consultant model was necessary but not sufficient to effectively change attitudes and classroom practices. Some staff felt uncomfortable with the consultant model and needed encouragement from someone they saw as a peer. Hence, the mentor component of EZ-PIP was developed to address these issues. The mentor model has gained respect as a valuable tool for increasing professionalism, competence, and skills (Hofsess, 1990).

The roles and responsibilities of mentors as listed in *The Early Childhood Mentoring Curriculum: A Handbook for Mentors* are as follow:

- Sharing information with the protégé about program procedures, guidelines and expectations
- Linking the protégé to appropriate resources
- Sharing teaching strategies or information about early childhood caregiving
- Offering support by listening and sharing your own experiences
- Giving guidance and ideas about discipline, scheduling, planning, organizing the day, and other topics,
- Assisting the protégé in arranging, organizing and/or analyzing the physical setting
- Allowing the protégé to observe you at work and then to discuss what was observed
- Promoting self-observation and analysis
- Encouraging the protégé to reflect on her career goals, and
- Modeling professionalism (such as good working relationships with peers, and continuing professional development)

Additionally we asked that our Mentors provide information specific to working with young children with disabilities in inclusive childcare settings.

In the first year of providing this component the Mentors were identified from the pool of EZ-PIP participants and invited to come to initial training. The Project Manager held an initial informational meeting with mentors' center directors to explain the commitment of providing Mentor teachers. This commitment included providing release time to the Mentor teacher so that she could visit her protégé at the protégés center and the understanding that protégés would also be visiting the host center. The project offered substitute reimbursement to participating centers so that there was no undue burden placed on the Mentor teacher's classroom or the protégé. We then provided eight hours of Mentor training in four two-hour sessions to prospective Mentors. An outline of the training sessions follows.

Session 1: Introduction - Defining Mentor Roles

- Roles and expectations of the mentor
- Character traits of successful mentors
- Defining Inclusion
- Importance of the Enterprise Zone- Preschool Inclusion Project

Session 2: Communication, trust building and confidentiality

- Strengthen trust building skills
- Positive feedback techniques
- Confidentiality in the childcare center
- "People First" language

Session 3: Reflective Teaching Practices and Nurturing the Nurturer

- Study stress management techniques
- Explore different self-reflection practices
- Understand necessity of self-validation

Session 4: Successful Mentor Practices

- Conflict resolution in the classroom
- Define emotional and factual observations
- Modeling appropriate behavior in the classroom.
- Troubleshooting ideas and experiences

In addition to the training sessions, all of the Mentors received an EZ-PIP Mentor handbook to help them provide more effective services. The Mentor handbook is divided into five sections consisting of:

1. Training Schedule and Mentor Support Meeting schedule
2. Support materials from the training sessions
3. Inclusion resources including a Statement of Beliefs, Inclusion Guide, Glossary of Special Needs, a list of Florida organizations that assist children with disabilities
4. Information on involving parents
5. Articles on Inclusion

Finally, we held Mentor support groups so that Mentors could share their experiences and concerns and ask for one another's guidance in situations where they did not know what to do. At one of the first Mentor support group meetings the Mentors developed the attached Mission Statement together to guide them in their work. The Mentors met monthly at first and then quarterly as they became proficient in their roles.

Challenges

This valuable component came with its share of challenges. Because this project was specifically designed to increase quality inclusive childcare opportunities, we had to find mentors who were experienced in providing inclusive childcare. This proved difficult, as there were very few childcare providers in our community who had long term experience in providing inclusive care. Another challenge was the perceived overlap between the roles of the Special Instruction Consultant and the Mentor and this caused some confusion for directors, childcare staff, the SICs and Mentors.

In the first year of the project we made the assumption that any mentor could work with any protégé. Because this was a model program we had a research component involved. The lead researcher assigned Mentors to protégés in a double blind format; in other words, protégés were assigned a mentor without being asked if they wanted one. It soon became apparent that this was not the best way to assure a positive outcome. The Mentoring relationship is built on trust and mutual respect and protégés who simply "received" a Mentor without the opportunity to make personal connections felt defensive, mistrustful and resentful. We also tried to have Mentors assigned from within the same childcare center and were surprised that this was not successful. The protégés felt that teachers from their own centers were more likely to report them to the director if they did something wrong. Additionally, the protégés felt that even though it was supposed to be an equal peer based relationship, there were issues of inequality and the relationships became strained.

In the second year we held a mixer event with Mentors and prospective protégés and asked them to make their own choices regarding their working relationships. The Mentors had a chance to introduce themselves and share some of their personal experiences and the protégés picked the person that they felt most comfortable with to be their Mentor. This method was more effective than the first year, but there were some issues with physical distance between the Mentors and protégés centers. Many of the Mentors were in schools in a rural area of deep south Miami-Dade County and the protégés for the second year were in schools in urban inner city centers.

Once the Mentor/protégé pair had been established the Mentors would visit the protégé's classrooms. The model was also supposed to provide for the protégés to visit the Mentors' classrooms, however this did not happen because the protégés did not have available substitutes. Another part of the model that did not occur was that we had envisioned that occasionally the pair would be able to meet "off-campus" for coffee or lunch to talk without the interruptions inherent in the classroom setting. There were some difficulties in providing release time for the Mentors and protégés to meet even with the substitute reimbursement component. Unexpected absences of other staff, inability to find a substitute, changes in schedules, forgotten appointments, and other events could easily disrupt the planned meeting of Mentors and protégés.

Feedback obtained from participants indicated that this component was one of the least understood parts of the model. Some directors did not see the value in having a Mentor teacher come to their center and some protégé teachers felt threatened by having someone more experienced in their classrooms. Additional information concerning all aspects of the evaluation component of this project is contained in Book 4 - Findings and Accomplishments.

Sample Case Studies

The following two case studies illustrate some of the strengths and weaknesses of the Mentor model (note: names and locations have been changed to protect the anonymity of all parties involved).

Case Study #1

This is a successful example of a Mentor/Protégé relationship that resulted from the implementation of the EZ-PIP Mentor component. In this case the Protégé and Mentor knew one another and actually worked at *the same center. While this arrangement had been problematic at other centers it was working well in this particular situation. The Protégé contacted her Mentor because she was not sure how to improve the learning experience for a child in her class who had a disability. Alex would become upset easily when he could not perform a task as quickly as his peers. Sometimes he would misbehave or become disruptive. The Mentor observed in the classroom and worked together with her protégé to develop a behavior management plan. They decided upon several behavioral management techniques where the child would receive individualized attention from both the providers and peers. With a little extra time and attention, Alex's behavior improved and the learning process was enhanced. At the same time the protégé gained a greater understanding of behavioral management techniques, while the Mentor increased her competencies in order to better help other providers in need.*

Case Study #2

This example depicts an unsuccessful Mentor/Protégé relationship. The Mentor was assigned to a rural childcare center in Miami-Dade County. The protégé had not been made aware of the Mentor/Protégé component and was unreceptive and uncooperative with the Mentor. The Mentor did not have an opportunity to establish a relationship prior to observing in the classroom. When the Mentor visited she observed a *child, Sam, who appeared to have special needs, specifically, a hearing impairment. The Mentor approached the Protégé teacher with her concern but the concern was dismissed. The Mentor also spoke with the assistant teacher in the same classroom who shared her concern. However, the assistant felt that she would be stepping over her boundaries if she brought the concern to the director. The Mentor went to the director of the center with her concern regarding Sam's hearing but the director was unwilling to pursue the issue and stated that she relied on the Protégé teacher's opinion. The Mentor/Protégé association was off to a rocky start and never developed into a trusting open relationship. Two months later the Mentor decided not to pursue the relationship. In a follow-up hearing screening that was conducted at the childcare center by an outside agency, it was discovered that Sam was in fact profoundly hearing impaired. The Mentor was frustrated by the lack of initial response to her concerns but felt reassured that Sam would at last get the help that he needed.*

Recommendations

In replicating this component of the model we recommend the following guidelines.

- Ensure that all participants including Mentors, protégés and directors fully understand the purpose of the Mentor component and are committed to its success.

- Ensure that staff who are not directly involved as Mentors and protégés also understand the purpose of the component and are supportive of it.
- Set up a qualified substitute pool in advance of arranging the Mentor component.
- Provide substitute reimbursement for both the Mentors and protégés classrooms.
- Provide opportunities for Mentors to meet as a group or individually with the Project Manager to discuss issues and concerns and to give and receive feedback.
- Maintain a relationship with the directors at Mentor and protégé's centers so that issues can be addressed before they become problematic.

References

Bellm, D., Whitebook, M. & Hnatiuk, P. (1997). *The Early Childhood Mentoring Curriculum, A Handbook for Mentors*. National Center for the Early Childhood Work Force, Washington, D.C.

Hofsess, D. (1990). The Power of Mentoring: A Moving Force in Staff Development. *Journal of Staff Development*, 11(2), 20-24.

Enterprise Zone - Preschool Inclusion Project

Mentor Component

Mission Statement

(Developed by participating mentors)

The Enterprise Zone -- Preschool Inclusion Project Mentor Program strives to create an open and honest relationship between mentors and protégées. All parties involved wholeheartedly complete and implement all knowledge and data gleaned in the mentor leadership course, using all related resources wisely. Mentors and protégées continually endeavor to maintain mutual respect. Learning between mentor protégées is reciprocal; knowledge is shared and wisdom is gained. The villagers work together in the best interest of the children

The Enterprise Zone-Preschool Inclusion Project

Mentor Application Package

- Sample Mentor Recruitment Letter
- Mentor Component Overview
- Mentor Component Fact Sheet
- Informed Consent
- Mentor Profile
- Protégé Teacher Application Forms
- Letter of Acceptance

EZ-Preschool Inclusion Project

Date

Dear Center Director,

Re: Teacher Mentors

I hope things are well. I am asking if you could recommend five teachers that could serve as mentors to preschool teachers and early childhood educators participating in our Enterprise Zone Preschool Inclusion Project. The project is an inclusive training program designed to assist community childcare programs to comply with the Americans with Disabilities Act and better serve children with disabilities and their families. The teachers you recommend would be specially trained to mentor teachers in these private childcare programs. We need those educators who have experienced serving children with special needs in their classrooms. This is a 10-hour training course that will encourage reflective practices and personal growth and development. We anticipate that the training program to start in DATE.

An application process will match mentors and mentees. The mentor is expected to maintain contact with their mentees over the year. Meeting time is strongly recommended. The program encourages the mentor to visit the mentees' classroom and vice versa. The project can provide the mentor's home center with substitute reimbursement if that is necessary. Also, the mentors will be provided with a stipend to supplement their time with the mentees. In addition to mentoring, the mentees are attending large group training. The mentor will enforce the training topics and encourage personal growth and professionalism.

I hope you can recommend some of your teachers to participate in this exciting new program.

Sincerely,

Jane Doe
Project Manager

cc: Ms. Jane Doe
Mr. John Doe

Enterprise Zone-Preschool Inclusion Project

Mentor Component Overview

The mentor component provides early childhood teachers and childcare providers with individual assistance with the changing role of the profession. Caregivers who may experience difficulties transforming their learning environment into one that serves all children need a mentor. This component is designed to improve the professional development of the early childhood teacher or childcare provider.

The program matches protégée early childhood educators and provides teachers with qualified peers to increase the confidence and provide support to those who are beginning to expand their service to all children.

The mentor must have prior training and experience with inclusionary practices and techniques for the early childhood environment. Additionally, the prospective mentor must minimally complete eight hours of mentor training. A mentor must have a CDA or equivalent, at least two years working in an inclusive classroom or program, and be committed to the program.

Prior to the beginning of training, applications for both the prospective mentor and the prospective mentee/protégée must be distributed and collected. The applications have multiple purposes. The most important is to establish a profile of the applicant. The application requests demographic information along with references, level of training and experience. The application also requires a short personal statement regarding the applicants anticipated benefits from the program and specific areas of need. The applicant forms are used to match the mentors with their protégées. Another purpose of the application is to establish the Center Director's agreement in support of either the mentor or the protégée's participation in the program. Mentor participants are asked to complete a letter of acceptance. (See attached for samples of all forms and letters).

Enterprise Zone-Preschool Inclusion Project

Mentor Component

Fact Sheet

What is the EZ-PIP Inclusion Mentor Program?

The mentor program pairs teachers and directors, who are experienced in working in an inclusive program, with colleagues who have taken the EZ-PIP training and are ready to include children with special needs in their classrooms. The goals of the program include:

- Providing technical assistance and support to teachers and directors who are working in inclusive programs
- Recognizing and compensating teachers and directors who are experienced in creating inclusive programs
- Enhancing the quality of inclusive programs
- Increasing staff retention

How do teachers and directors become mentors and protégées?

To become a mentor, you must:
- Have a CDA or equivalent a the college level
- Have at least two years experience working in an inclusive classroom or program
- Work in a program that meets the NAEYC criteria for Developmentally Appropriate Practices
- Demonstrate a commitment to the Mentor Program

To become a protégée, you must:
- Have completed the EZ-PIP training and be employed in an inclusive program
- Be motivated to learn, eager to excel and demonstrate a sense of responsibility

What are the benefits of the Mentor Program?

Mentors receive:

- Recognition as professionals who are experienced in creating inclusive programs
- Training in leadership skills through a twenty hour course
- Satisfaction from assisting and supporting a colleague who is new to creating inclusive programs
- A stipend for mentoring

INFORMED CONSENT

Dear Mentor

Purpose

We would like for you to be part of a study on the effectiveness of inclusion training being offered to child care providers in Dade County. The program is called the Enterprise Zone-Preschool Inclusion Project (EZ-PIP). The program was developed because there is great need to serve children with disabilities in Dade County and many child care providers feel that they do not have enough training on how to optimize the development of these children. This program will provide such training to child care providers, as well as helping to expand the opportunities to children with special needs to attend quality child care programs in their neighborhoods. Your participation in this study will help us document the impact of our training program.

Procedure

As a mentor, if you agree to be in the study, you will be involved in training and in filling out questionnaires. Training will consist of approximately ten 2-hour sessions for each year you serve as a mentor. Participation in the project includes the attendance of staff development sessions that may occur during your workday. You will be asked to fill out information at the beginning and the end of training. These questionnaires ask about your experiences of being a mentor. The time involved in answering the questions will generally not exceed 1 hour at each of the two sessions. You will receive a copy of this consent form.

Risks

There are no risks to you for participating in this study.

Benefits

You will be provided training in mentoring and will be given a certificate documenting the successful completion of this continuing education program.

Alternatives

Participation in this project is completely voluntary. You can withdraw from participating in EZ-PIP at any time. Should you say "Yes" and later change your mind, you have the right to withdraw your consent. There will be no penalties for withdrawal from participation.

Confidentiality

If you decide to participate in EZ-PIP, all information will be stored by number only and will be kept confidential to the full extent permitted by law. Authorized University employees or other agents who will be bound by the same provisions of confidentiality may also review your records for audit purposes. The results of the study will be published as group data without revealing the identity of any participant.

Questions

You may ask and will receive answers to any questions related to this study. If you have any questions about this study, please feel free to contact Dr. Susan Gold or Faye Farnsworth at (305) 243-6624. If you have any questions about your rights as a research subject, you may contact Maria Arnold, Institutional Review Board Administrator at (305) 243-3327.

______________ Subject's Signature ______________ 11/29/99 Date

I.R.B.
APPROVAL DATE: 1/30/98
INITIALS: M.A.

University of Miami
Mailman Center for Child Development
Enterprise Zone-Preschool Inclusion Project

MENTOR PROFILE

Congratulations on being selected to become a Mentor in the EZ-PIP Inclusion Mentor Program. Please complete all sections of this survey. The purpose of the survey is to assist us in effectively pairing Mentors and Protégés.

Have you….(please check)

____ Completed the information Employer's Agreement for Mentor to participate?

____ Indicated your highest level of training?

____ Completed the Personal Statement?

Please send completed Mentor Profile to :

Susan Gold, Ed.D.
University Of Miami
Mailman Center for Child Development
P.O. Box 016820
Miami, Fl. 33101

Last Name ______________________________ First Name ______________________________

Home Phone ______________________________ Best Time to reach you ________________

Home Address __________________________ City, State, Zip _______________________

Present Work Site ____

How long at the above location ____

Job title ____________________________________ Age of children in your care ___________

Work Address __________________________ City, State, Zip _______________________

Work Phone ______________________________ Best time to reach you _________________

EMPLOYER AGREEMENT FOR MENTOR PARTICIPATION IN THE EZ-PIP INCLUSION MENTOR PROGRAM

I agree to support this mentor Director or Teacher in his or her participation of the EZ-PIP Inclusion Mentor Program. I am aware that the mentor will be away from the preschool or center, visiting the Protégé's program every three weeks for the duration of the program. I agree to support the Mentor in the performance of his or her duties.

Specifically I agree to:

1. Allow the Mentor to spend time at the protégés center
2. Allow the Protégé to spend time at the Mentor's center
3. Allow the field instructor to make visits to the Mentor's center.

Signature of the Employer ____________________________ Date ___________________

Name of the Employer (please print) ____

LEVEL OF TRAINING

Place a √next to each level of training you have completed and specify major:

____ CDA or CDA-E

____MITCH Modules

____ AA/AS Degree in ________________________

____ BA/BS Degree in ________________________

____ Graduated Degree in ______________________

List the last two professional Workshops or conference seminars you attended. Briefly describe the content.

1. ____

2. ____

PERSONAL STATEMENT

(You may use more paper if necessary)

1. Briefly describe (A) your program's philosophy, (B) the ages of children in your program(C) the strengths of your inclusion program

2. Indicate briefly, your areas of expertise. Describe areas in which you could best assist a protégé.

Signature____Date_______________

PROTÉGÉ TEACHER APPLICATION PACKET

Consideration to become a Protégé Teacher in the EZ-PIP Inclusion Mentor Teacher Program involves submitting an application packet to the Selection Committee. Completed applications will be reviewed by the Selection Committee. The following documents need to be included in order for your application packet to be complete.

- Protégé Teacher Application Form
- Three recommendations from Early Childhood Professionals who can attest to your willingness to learn and commit to improving the quality of your teaching in an inclusive classroom.
- Level of Training
- Personal Statement

Have you... (please check)

_____ Completed the Protégé Teacher Application?

____ Received your program director's signature on page 1?

____ Included three (3) recommendations from Early Childhood Professionals?

Please send completed application packet to:

Selection Committee
Susan Gold, Ed.D
Mailman Center for Child Development
P.O. Box 016820
Miami, Florida 33101

PROTÉGÉ TEACHER APPLICATION FORM
EZ-PIP Inclusion Teacher Mentor Program

Last name ______________________ First name ______________________

Home Phone ______________________ Best time to reach you ____________

Home address ____

City and Zip code ____

Name of your present work site ____________________________________

How long have you worked at the above site? __________ Years ________ Months

Job title ______________________ Age of the children in your class ______

Work address ____

City and Zip code ____

Work phone ______________________ Best time to reach you ____________

What are your current work hours?

Monday __________ Tuesday __________ Wednesday __________

Thursday __________ Friday __________

DIRECTOR'S AGREEMENT FOR PROTÉGÉ TO PARTICIPATE IN THE EZ-PIP INCLUSION MENTOR TEACHER PROGRAM

I agree to support the application of this candidate for selection as a Protégé Teacher. Should this candidate be selected, I agree to support the Protégé in the performance of his or her duties and pursuit of career goals. Specifically, I agree to:

1. Allow the protégé to work with the Mentor in the Protégés classroom
2. Allow the protégé to work with the Mentor in the Mentor's classroom
3. Provide weekly conference time for the Protégé and Mentor
4. Allow the Field Instructor to make drop-in visits to the Protégés classroom
5. Maintain the Protégés same classroom assignment for the duration of the Protégé experience
6. Attend three (3) meetings for Directors of Protégés and Mentors
7. Hire substitute teachers (will be paid for by EZ-PIP) for protégés when they are participating in EZ-PIP Inclusion Mentor Program activities.

Director's Name (please print) ____________________________________

Director's Signature ______________________________ Date ________

Experience:

List your previous experience in child care or preschool teaching (in order of most recent first). Feel free to use extra sheets of paper if necessary.

1) Name of school or center ______________________________

Address ______________________________

City & zip code ______________ Dates employed ______________

Phone ____________ Supervisor's name ______________

Job title ______________ Age of children you worked with ________

Job description ______________________________

Reason for leaving ______________________________

2) Name of school or center ______________________________

Address ______________________________

City & zip code ______________ Dates employed ______________

Phone ____________ Supervisor's name ______________

Job title ______________ Age of children you worked with ________

Job description ______________________________

Reason for leaving ______________________________

3) Name of school or center ______________________________

Address ______________________________

City & zip code ______________ Dates employed ______________

Phone ____________ Supervisor's name ______________

Job title ______________ Age of children you worked with ________

Job description ______________________________

Reason for leaving ______________________________

References

Please submit (3) letters of recommendations, two from Early Childhood professionals and one from a parent who can attest to your teaching ability and classroom skills. Request specific details about your ability and willingness to learn and improve your teaching skills, the type of learning environment you maintain, the quality of communication with children, co-workers and parents.

Level of Training

Place a ✓ next to each level of training you have completed and specify major:

______ CDA or CDA-E

______ Mitch Modules

______ AA or AS Degree in ______________________

______ BA or BS Degree in ______________________

______ Graduate Degree in ______________________

List the last two professional workshops or conference seminars you attended. Briefly describe the content.

1. ____

____

____

____

____

2. ____

____

____

____

____

PERSONAL STATEMENT

(You may use more paper if necessary)

1. Indicate briefly why you wish to be chosen as an EZ- PIP Inclusion Protégé Teacher and how you think you would benefit from this role. Please discuss experiences, education, personal qualities and background which would make you especially receptive as a Protégé.

2. Briefly describe the concerns, interests and areas in which you would most like mentor assistance. Please confer with your director or supervisor in completing this section.

Signature ______________________________

Director's signature ______________________________

Date: ____________

University of Miami
Mailman Center for Child Development
Enterprise Zone-Preschool Inclusion Project

LETTER OF ACCEPTANCE

I, ____________________________, agree to participate in the Enterprise Zone-Preschool Inclusion Project and understand that I will be required to attend staff development sessions/or meetings which will occur during my workday.

Please check your role in your Child Development Center/Family Childcare Home:

Family Childcare Provider	____
Administrator:	____Center Director ____Assistant Director ____Other (please specify)________________
Staff:	____Early Childhood Teacher ____Early Childhood Teacher Assistant/Aide ____Other (please specify)________________
Mentor:	____**Center Director** Mentor ____Early Childhood **Teacher** Mentor ____Other (please specify)________________

As a family Child Care Provider, I, __________________________, agree to participate in a minimum of approximately 32 hours of training in appropriate practices for family child care homes and 13 inclusion provider development sessions.

As an administrator, I, __________________________, agree to attend Center Director meetings (approximately five 2 hour meetings per year)

As an Administrator and/or Staff, I, ______________________________, agree to participate in the 13 Inclusion training sessions for staff development consisting of eight (8) sessions in the first year and five (5) additional sessions in the second year.

As a mentor, I, __________________________(having completed the 13 requisite Inclusion Training Sessions) agree to attend regular mentor sessions (approximately ten 2-hour sessions per year)

Signature______________________________ Today's Date__________________

Center________________________________ Telephone____________________

Mentoring Training Program

- Session 1: Introduction – Defining Mentor Roles
- Session 2: Communication Trust Building and Confidentiality
- Session 3: Reflective Teaching Practices and Stress Management
- Session 4: Successful Mentor Practices

1

Introduction: Defining Mentor Roles

Objectives:

- Understand the roles and expectations of the mentor
- Understand personal character traits to becoming a successful mentor
- Define Inclusion
- Understand the importance of the Enterprise Zone Preschool Inclusion Project (EZ-PIP)

Materials:

- "Relaxation toys" such as slinkys, rubber balls, bubbles, silly glasses, etc…
- Division for Early Childhood (DEC) Position on Inclusion
- "Statement of Beliefs" (handout)
- *The Early Childhood Mentoring Curriculum: A Handbook for Mentors* (Bell, Whitebook, & Hnatiuk, 1997).
- Flip chart paper and markers

Teaching Strategies

I. **Housekeeping** (5 minutes) - Welcome participants and invite them to use the toys that are on the tables at any time during the session.

II. **Icebreaker** (15 minutes) – Distribute the handout titled “People Poll”. Ask participants to find an individual in the room who shares similar characteristics, interests, or possessions.

III. **Reflections of a Mentor** (20 minutes) – The presenter or guest speaker will share personal experiences as a mentor and as a protégée. After sharing personal experiences ask the participants to individually answer questions 1 – 6, p. 20 - 21 from the book, *The Early Childhood Mentoring Curriculum: A Handbook for Mentors* (Bell et al.,1997).

IV. **Expectations** (10 Minutes) – Take this time to clarify what the expectations and responsibilities are for both parties; mentors and protégées.

- Attendance – Prospective mentors must complete 8 hours of training. Participants must sign an attendance sheet at the beginning of each session. Discuss expected release time from their prospective work and availability of funds to for substitutes.

- Homework Projects – activities are assigned to participants. Encourage participants to read news articles regarding children with disabilities and to share such articles with the group at the next meeting. Articles can be kept in the handbook for quick reference.
- Mentor/Protégée meetings and schedules are established between the mentor and the protégée. Meetings should be made at both the mentors and protégées' programs. This provides both with reciprocal opportunities to learn and understand their respective working environments.
- Stipends – It is encouraged to provide a stipend for the mentors as an incentive to establish the necessary relationships with their protégées.

V. **Break** (5 minutes - Optional)

VI. **Group activity** (20 minutes) – Using flipchart paper divide the large group into small groups and ask them the to answer the following question, "What makes a good mentor?" (Bellm et al., 1997, p.19). Using the answers from the previous activity, ask the small groups to share their answers with the large group to answer the new question.

VII. **Defining Early Childhood Inclusion** (15 minutes) – The presenter can begin this section with on discussion of inclusion. Inclusion is the practice of providing children with disabilities or special needs the opportunity to learn together with other children in their neighborhoods in a stimulating natural environment encouraging developmentally appropriate practices. The handout entitled "Statement of Beliefs" and/or DEC's Position on Inclusion may be read as a group to stimulate the discussion.

VIII. **Review** (15 minutes) – Provide a brief summary of the EZ-PIP training to refresh its content to participants. Ensure that mentors are aware of were in the training process of inclusion are their respective protégées. Provide or distribute the community resource list to increase the participant's knowledge and awareness of existing community service providers.

IX. **Conclusion/ Wrap-up/Questions and Answers** (5 minutes)

References

Bellm, D., Whitebook, M. & Hnatiuk, P. (1997). *The Early Childhood Mentoring Curriculum, A Handbook for Mentors*. National Center for the Early Childhood Work Force, Washington, D.C.

Sandall, S., McLean, M. E., & Smith, B. J. (2000). *DEC Recommended Practices in Early Intervention/ Early Childhood Special Education*. Denver: Division fro Early Childhood of the Council for Exceptional Children.

Enterprise Zone-Preschool Inclusion Project

Mentor Training

Homework Assignment #1

Session One Assignment

Assuming that resources are unlimited, describe the support systems or patterns you would find most helpful as you engage in your mentoring role. Describe an ideal support system. Consider the following questions:

- Who should the support person be?
- What are their roles and functions?
- How often should they be available?
- Should the mentors themselves form a peer support group?
- How and when should support persons meet?
- In what ways could you help each other?

PEOPLE POLL

Find individuals in the room who meet the following requirements. Introduce yourself and get their signature.

Find someone who:

1. Was born in the same month as you. ____________
2. Is wearing an item of clothing you like. Congratulate them on their sense of style. ____________
3. Has a favorite vacation spot. Ask them why it is their favorite. ____________
4. Has the same number of students in their classroom as you do. ____________
5. Was born in the same state as you. ____________
6. Is the same exact height as you. ____________
7. Drives the same make of car as you. ____________
8. Has been teaching as long as you have. ____________
9. Is wearing the same color shoes as you are. ____________
10. Has a favorite classroom story. Share a favorite story with them. ____________
11. Has a child in their classroom with your first name. ____________
12. Has the same favorite flavor of ice cream as you. ____________
13. Enjoys the same hobby as you do. ____________

THE DIVISION FOR EARLY CHILDHOOD

Division for Early Childhood (DEC) Position on Inclusion

ADOPTED: April, 1993
Revised: December, 1993
Reaffirmed: 1996
Updated: 2000

Inclusion, as a value, supports the right of all children, regardless of abilities, to participate actively in natural settings within their communities. Natural settings are those in which the child would spend time had he or she not had a disability. These settings include, but are not limited to home, preschool, nursery schools, Head Start programs, kindergartens, neighborhood school classrooms, child care, places of worship, recreational (such as community playgrounds and community events), and other settings that all children and families enjoy.

DEC supports and advocates that young children and their families have full and successful access to health, social, educational, and other support services that promote full participation in family and community life. DEC values the cultural, economic, and educational diversity of families and supports a family-guided process for identifying a program of service.

As young children participate in group settings (such as preschool, play groups, child care, kindergarten) their active participation should be guided by developmentally and individually appropriate curriculum. Access to and participation in the age appropriate general curriculum becomes central to the identification and provision of specialized support services.

To implement inclusive practices DEC supports: (a) the continued development, implementation, evaluation, and dissemination of full inclusion supports, services, and systems that are of high quality for all children; (b) the development of preservice and inservice training programs that prepare families, service providers, and administrators to develop and work within inclusive settings; (c) collaboration among key stakeholders to implement flexible fiscal and administrative procedures in support of inclusion; (d) research that contributes to our knowledge of recommended practice; and (e) the restructuring and unification of social, educational, health, and intervention supports and services to make them more responsive to the needs of all children and families. Ultimately, the implementation of inclusive practice must lead to optimal developmental benefit for each individual child and family.

Endorsed by NAEYC—April 1994, April 1998

Permission to copy not required—distribution encouraged.

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STATEMENT OF BELIEFS

We believe:

** Inclusion, as a value, supports the right of all children, regardless of their diverse abilities, to participate actively in natural settings within their communities. A natural setting should be a developmentally appropriate environment in which all children succeed.*

**successful inclusion requires*

- *developmentally appropriate settings*
- *time*
- *support*
- *education and training*
- *resources*
- *involvement*
- *commitment*

** in and support full access to health, social service, education, and other supports and services for young children and their families that promote full participation in community life*

** in and value the diversity of families and support a family guided process for determining services*

** in collectively promoting the mission of inclusion through*

- *educating teachers, parents and leaders in the community,*
- *creating partnerships,*
- *supporting projects to implement inclusion*

** successful inclusion is achieved one child, one school, one attitude at a time*

Adapted from The Division for Early Childhood (DEC) Position on Inclusion

2

Communication, Trust building and Confidentiality

Objectives:

- Strengthen trust building skills
- Discuss positive feedback techniques
- Define confidentiality and it's role in the childcare center
- Understand the importance of "People First" language

Materials:

- ✓ "Relaxation toys" such as slinkys, rubber balls, bubbles, silly glasses, etc…
- ✓ Bandanas or scarves to use as blindfolds
- ✓ Flip chart paper and markers
- ✓ *The Early Childhood Mentoring Curriculum* (Bellm et al., 1997)
- ✓ Words with Dignity (handout)
- ✓ Baskets or other containers for "Play Ball" activity

Teaching Strategies

I. **Housekeeping** (5 minutes) - Welcome participants and invite them to use the toys that are on the tables at any time during the session.

II. **Trust Walk** (25 minutes) – Ask participants to pair up. Give one person in each pair a bandana to use as a blindfold. One person in the pair volunteers to be blindfolded and the other to be the guide. The guide should assist the person who is blindfolded as they negotiate through the room, the building or the grounds. This activity helps build trust because the person who cannot see has to rely on her guide to make sure that she is safe and secure. After the trust walk give the participants the opportunity to discuss the experience and write on the flip chart what it felt like to be the guide and to be blindfolded. Help them process these feelings and apply them to the mentor/protégé relationship.

III. **Communication and Confidentiality discussion** (40 minutes) - Present a brief review of the fundamentals of effective communication. The presenter may want to remind participants of the content of Session 10 from the EZ-PIP training curriculum (Book 1) or may want to present a summary of this session. After presenting the review on effective communication and relating it to the mentor/protégée relationship discuss in detail the delicate issue of confidentiality. Examine the laws as they pertain to keeping certain information private in regards to children and families.

IV. **Break** (5 minutes – Optional)

V. **Activity-"Play Ball"** (20 minutes) – Using Chapter 6 from *The Early Childhood Mentoring Curriculum* (Bellm et al., 1997), review and discuss appropriate ways of "giving and receiving feedback". Continue with the following activity to help participants practice "giving and receiving feedback". Ask participants to find their partner from the trust walk. Distribute a small rubber ball (or make balls from foil) and a basket to each pair. Ask them to stand 10 feet apart and for one of the pair to try to throw the ball into the basket. The person holding the basket should give positive feedback to the person attempting to throw. You may want to model inappropriate or negative feedback as a contrast to positive feedback. For example negative feedback or criticism would include such comments as "You're not very good at this, are you?" "Why can't you ever get it right?", "Didn't anyone ever teach you how to do this?". Positive feedback would include comments like "You're really getting better at this, you must have been practicing!" "Wow, that was close, you almost got it", and "Good try, let's do it again!". Remind the participants that when they are working with their protégés they should try to use positive feedback whenever possible.

VI. **Discussion** (15 minutes) - Distribute the handout "Words with Dignity" to all participants and use it as a springboard for a discussion on using "people first" language.

VII. **Conclusion/Wrap-up/Questions and Answers** (5 minutes)

References

Bellm, D., Whitebook, M. & Hnatiuk, P. (1997). *The Early Childhood Mentoring Curriculum, A Handbook for Mentors.* National Center for the Early Childhood Work Force, Washington, D.C.

Enterprise Zone-Preschool Inclusion Project

Mentor Training

Homework Assignment #2

Session Two Assignment

To help you sort out the difference between mentoring and supervising, choose three of the following scenarios and answer the following questions about each:

- What could or should a mentor do in each situation?
- What could or should a supervisor do?
- What are the limits and opportunities in each role?

1. The protégée is consistently late for meetings, observations, or other agreed upon activities.
2. The protégée does not complete paperwork or other agreed upon tasks.
3. After observing the protégée in her classroom or home, you feel she needs more training or skill development in a particular area (e.g., setting up the play and learning environment; developing well thought out lesson plans; more sensitivity to the child with special needs; or equal play and learning opportunities for boys and girls).
4. You observe the protégée yelling at or using sarcasm with children when she is impatient.
5. A child tells you or you suspect that the protégée has used physical punishment.

COMMUNICATION

The process of sharing ideas, thoughts, feelings and opinions among people by means of gestures, speech, writing and body language. Body language is a combination of several things. It includes how we move, for example easily or abruptly. It also includes our facial expressions.

Actually, body language and gestures are very powerful ways to get a message across.

Words with Dignity

By using words with dignity, we encourage equality for everyone

Use words with dignity...	*Not these words...*
Person with a disability/disabled/disability	Cripple/handicapped/handicap/invalid (Literally, invalid means "not valid." Do not use it.)
Person who has/person who experienced/person with (e.g., person who has cerebral palsy)	Victim/afflicted with (e.g., victim of cerebral palsy)
Uses a wheelchair	Restricted, confined to a wheelchair/wheelchair bound (The chair enables mobility. Without the chair, the person is confined to bed.)
Non-disabled	Normal (Referring to non-disabled persons as "normal" insinuates that people with disabilities are abnormal.)
Deaf/does not voice for themselves/nonvocal	Deaf mute/deaf and dumb
Disable since birth/born with	Birth defect
Emotional disorder/mental illness	Crazy/insane
Seizures	Fits
Developmental delay	Slow

Preferred Terminology...

Blind (no visual capability)
Deaf/profoundly deaf (no hearing capability)
Hearing impaired (some hearing capability)
Visually impaired (some visual capability)
Hemiplegia (paralysis of one side of the body)
raplegia (loss of function in lower body only)
Quadriplegia (paralysis of both arms and legs)

Negative Terminology...

Abnormal
Spastic
Stricken
Suffer
Pitiful
Poor
Incapacitated
Stricken with
Disfigured
Burden
Condition
Deformed
Tragedy
Unfortunate
Physically challenged
Differently abled
Palsied
Pathetic
Imbecile
Maimed
Moron

Disability Etiquette

Basic Guidlines...

✔ Make reference to the person first, then the disability. Say "a person with a disability" rather than "a disabled person." However, the latter is acceptable in the interest of conserving print space or saving announcing time.

✔ The term "handicapped" is derived from the image of a person standing on the corner with a cap in hand, begging for money. People with disabilities do not want to be recipients of charity. They want to participate equally with the rest of the community. A disability is a functional limitation that interferes with a person's ability to walk, hear, talk, learn, etc. Use "handicap" to describe a situation or barrier imposed by society, the environment or oneself.

✔ If a disability is not germane to the story or conversation, don't mention it.

✔ Remember, a person who has a disability is not necessarily chronically sick or unhealthy. He or she is often just disabled.

✔ A person is not a condition, so avoid describing a person in such a manner. Don't present someone as an "epileptic" or "a post polio." Say, "a person with epilepsy" or "a person who has had polio."

Common Courtesies...

♿ Don't feel obligated to act as a caregiver to people with disabilities. It is all right to offer assistance to a person with a disability, but wait until your offer is accepted *before* you help. Listen to instructions the person may give.

♿ Leaning on a person's wheelchair is similar to leaning or hanging on a person and is usally considered annoying and rude. The chair is a part of one's body space. Don't hang on it!

♿ Share the same social courtesies with people with disabilities that you would share with anyone else. If you shake hands with people you meet, offer your hand to everyone you meet, whether or not they are disabled. If the person with a disability is unable to shake your hand, he or she will tell you.

♿ When offering assistance to a person with a visual impairment, allow that person to take your arm. This will enable you to guide, rather than propel or lead the person. Use specific directions, such as "left one hundred feet" or "right two yards," when directing a person with a visual impairment.

♿ When planning events which involve persons with disabilities, consider their needs before choosing a location. Even if people with disabilities will not attend, select an accessible spot. You would not think of holding an event where other minorities could not attend, so don't exclude people with disabilities.

Conversation...

✔ When speaking about people with disabilities, emphasize achievements, abilities and individual qualities. Portray them as they are in real life: as parents, employees, business owners, etc.

✔ When talking to a person who has a disability, speak directly to that person, not through a companion.

✔ Relax, don't be embarrassed if you use common expressions such as, "See ya later" or "Gotta run," that seem to relate to a person's disability.

✔ To get the attention of a person who has a hearing impairment, tap them on the shoulder or wave. Look directly at the person and speak clearly, slowly and expressively to establish if they read lips. Not all people with hearing impairments can read lips. Those who do, rely on facial expressions and body language for understanding. Stay in the light and keep food, hands and other objects away from your mouth. Shouting won't help. Written notes will.

✔ When talking to a person in a wheelchair for more than a few minutes, place yourself at eye level with that person. This will spare both of you a sore neck.

✔ When greeting a person with a severe loss of vision, always identify yourself and others. For example, say "On my right is John Smith." Remember to identify persons to whom you are speaking. Speak in a normal tone of voice and indicate when the conversation is over. Let them know when you move from one place to another.

To find out how to achieve independence on behalf of persons with disabilities, call the staff at
MERIL ~1504B N. 36th St.~St. Joseph, MO 64506~816-279-8558(v)~816-279-1550(fax)~816-279-4943(TTY)

*Words with Dignity copied from a flyer produced by Paraquad, a CIL in St. Louis, Missouri. Thanks Paraquad!

3

Reflective Teaching Practices and Stress Management Techniques

Objectives:

- Study stress management techniques
- Explore different self-reflection practices
- Understand necessity of self-validation

Materials:

- ✓ "Relaxation toys" such as slinkys, rubber balls, bubbles, silly glasses, etc…
- ✓ Flip chart paper and markers
- ✓ Relaxation Exercises (handout)
- ✓ Everyday Thanksgiving (handout)
- ✓ Things not to do to relax (handout)
- ✓ How to Pay Attention AND Practice Relaxation (handout)
- ✓ Relaxation Takes PRACTICE (handout)

- ✓ *The Early Childhood Mentoring Curriculum: A Handbook for Mentors* (Bellm et al., 1997)
- ✓ Role Play Activities (handout)

Teaching Strategies

I. **Housekeeping** (5 minutes) - Welcome participants and invite them to use the toys that are on the tables at any time during the session.

II. **Stress Management Techniques** (15 minutes) - Group leader either reads aloud or plays a tape of the handout entitled "Relaxation Exercises" and guides participants through the exercise.

III. **Relaxation discussion** (5 minutes) - Distribute additional handouts on relaxation, stress management and meditation to all participants and encourage them to read them on their own. Ask how many participants regularly practice some form of relaxation.*

- ✓ **Review** (30 minutes) – Discuss reflective practices based on information drawn from Unit 3 in *The Early Childhood Mentoring Curriculum: A*

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* Special thanks to Michele D. Scott for permission to use the handouts from her session entitled "From the Inside Out: Nurturing the Nurturer". For more information contact Michele at md_scott@bellsouth.net or call **305 685-9683**

Handbook for Mentors (Bellm et al., 1997). Focus specifically on the "Questions that Encourage Reflective Practices" section.

IV. **Checklist** (10 minutes) – Have participants complete the checklist for mentors entitled "Taking the Pulse of Your Relationship" on page 74 in *The Early Childhood Mentoring Curriculum: A Handbook for Mentors* (Bellm & et al., 1997).

V. **Break** (5 minutes - Optional)

VI. **Role-play Activities** (25 minutes) – Ask participants to pair up. Have one person from each pair be the protégée and the other the mentor. Use the role-play activity sheet for assistance.

- ✓ **Diversity Wheel** (25 minutes) - Ask participants to get in pairs to work on the Diversity Wheel from page 46 in *The Early Childhood Mentoring Curriculum; A Handbook for Mentors* (Bellm et al., 1997). Complete the activity as described in the handbook.

VII. **Conclusion/Wrap-up/Questions and Answers** (5 minutes)

References

Bellm, D., Whitebook, M. & Hnatiuk, P. (1997). *The Early Childhood Mentoring Curriculum, A Handbook for Mentors*. National Center for the Early Childhood Work Force, Washington, D.C.

Enterprise Zone-Preschool Inclusion Project

Mentor Training

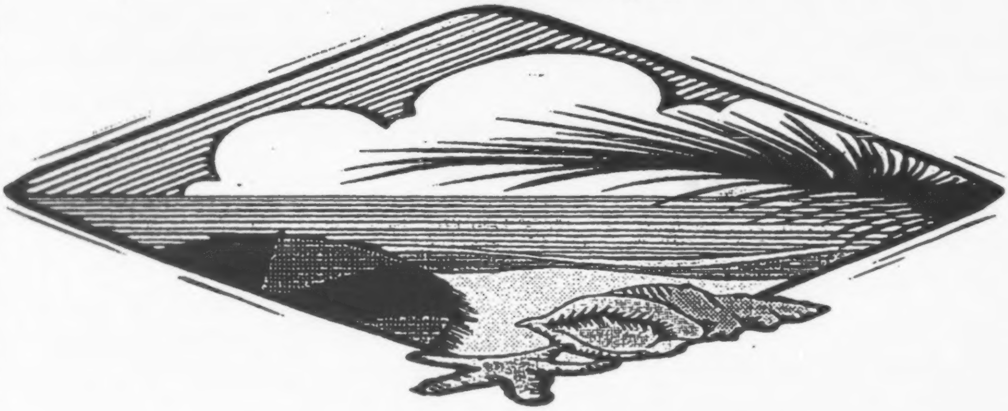
Homework Assignment #3

Session Three Assignment

- Practice the relaxation exercises you learned in class for at least ten minutes a day for an entire week.
- Write a three-paragraph paper about yourself. Include your strengths, weaknesses, and goals.
- Make a list of the qualities that you possess that will benefit your future mentor/protégée relationship.

Relaxation Exercises

Don't let the title throw you.



The next (fill in your own time) minutes is time for yourself. A time to calm down, (pause) to look inside, (pause) to mend (pause) and heal your spirit (pause). A time to relax your body, your mind and your spirit (pause for 5 to 30 seconds).

Begin this time with your eyes closed and letting go of all your conscious thoughts. Try to focus only on your breathing, in and out, (pause) in and out (pause). Focus on your breathing (pause), in (pause) and out (pause for 5 to 30 seconds).

Breathe easily and deeply (pause), in (pause) and out (pause). With each breath (pause) you can feel the tension, fading (pause). With each breath (pause) you are bringing, calm (pause), soothing (pause), relaxing breaths in (pause). You are breathing in relaxation (pause) and breathing away tension. Each breath you breathe out, takes away any thoughts (pause for 5 to 30 seconds).

Slowly, deliberately begin to focus on yourself (pause). Let go of the outside world, and turn your thoughts, to yourself (pause). Let go of any remaining thoughts (pause). Let go of your surroundings (pause). Drift into your own self (pause), into your own silence (pause), into your own calm (pause) and peaceful (pause) and serene being. Drift into yourself (pause) and relax (pause for 5 to 30 seconds).

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Let the muscles of your face go (pause). Let your face (pause) relax (pause), your forehead (pause), the muscles around your eyes (pause), your jaw (pause), your lips (pause), your tongue (pause), your throat (pause). All the parts of your face (pause) relaxed. Feel the relaxation like a warm liquid being poured over you (pause for 5 to 30 seconds).

Let this warmth flow down your neck (pause), cover your shoulders (pause), run down your arms (pause). Let the relaxed feeling flow, all, the, way, down, to your fingertips (pause for 5 to 30 seconds).
Let the relaxation continue down your body (pause). Feel the warmth flow down your spine (pause). Feel the warmth spread out across your chest (pause). Feel the warmth and just let it spread (pause), down (pause), down your whole body (pause). Feel the warm (pause) relaxed feeling continue to flow (pause) down to your legs. Feel it spread through your thighs (pause), down your legs (pause) into your toes (pause for 5 to 30 seconds).

Feel your whole body covered with a soft (pause) warm (pause) relaxed feeling (pause). See yourself completely relaxed (pause). See deep within yourself (pause). Every muscle is loose (pause), warm (pause), relaxed. Deep inside (pause) you can feel the calm (pause), the stillness (pause), the quiet (pause), the peace (pause for 5 to 30 seconds).

Visualize and experience your emotions as calm (pause), and your spirit at peace (pause). Feel complete peace (pause) and tranquility (pause). Relaxed deep within yourself (pause), you can picture and experience your body (pause), mind (pause), emotions (pause), and spirit (pause) in complete harmony (pause). Experience the deep (pause) relaxation (pause for 5 to 30 seconds).

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Very gently, search for an image, a symbol, a word, or phrase that describes how you are feeling right now (pause). Very gently (pause) use this time to find a key to remind you what you are feeling, right now (pause for 5 to 30 seconds).

In slow motion let yourself begin to find your way back (pause), back to the here and now (pause). Allow yourself to slowly revive (pause), awaken your muscles (pause), slowly return, feel yourself begin to return (pause), feeling alert and refreshed (pause for 5 to 30 seconds).

Take a few deep breaths and gently stretch (pause). Start with your fingers and toes (pause). Gradually move into a full-body stretch (pause). Bring yourself to an awake sitting position. Before you resume your normal activity take a few more moments to reflect on your deep relaxation experience. Remember your key and relate this to you what it felt like to be deeply relaxed.

This key should be part of your future relaxation sessions. What you are working for is to be able to use this key to tune into that relaxed state. The better it fits, the more you recall it during your relaxation sessions, the better it will work for quick stress reduction. Think of it as a tranquilizer, without any side affects. If you find your key is not working, revisit the entire relaxation process and search for whatever you feel brings the essence of deep relaxation to your conscious mind.

Remember, the length of this Relaxation Exercise is totally up to you. If you tape the exercise (or have someone tape it for you), the pauses within the text are intended to be between 2 to 10 seconds. The longer pauses noted at the end of the paragraphs, are suggested for anywhere between 5 to 30 seconds. Only you can decide how much time you need or can manage to take for yourself.

A final reminder, it will do no good to try to cram a relaxation session in between phone calls, or when you don't have a clear mind on just how long you have. Carefully plan for the first few times, and you'll schedule the next ones. No Calgon necessary!

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V

How to Pay Attention AND Practice Relaxation

In order to practice this relaxation exercise, you will either have to read it through and try to remember key points or you can record the instructions and play them back to yourself. If you chose to try to remember the instructions, try to recall the basic order but don't talk to yourself. You won't be able to relax if you're telling yourself what to do! Also, listening to your own voice on tape makes some people uneasy.

If you record the instructions or have someone record them for you, be sure the instructions are spoken slowly and there is enough time to feel the experience between the instructions. The mission is not to get there in a hurry but to enjoy the journey along the way. Pay attention to the preparation instructions because getting yourself ready is part of the exercise.

Get in a comfortable position, but not so comfortable that you will fall asleep. It is usually suggested to keep the back bone straight. If lying down puts you to sleep- then sit up. Lean on a wall, use a reclining chair but since we are conditioned to sleep in bed, avoid lying on a bed.

You should be comfortable in the total environment, from your clothing to the room temperature. Turn off the phone if you have to and dedicate the however many minutes to yourself. This exercise is flexible and designed to vary in length. It will do no good to stress yourself out trying to fit a 30 minute session in to 15 or 20 minutes. Be reasonable with the time you can set aside and make the time yours.

When you first begin to take this time for yourself, it is perfectly normal to feel selfish, or even angry that it is so hard to do. Once you realize the world can spin without you turning it for at least a few minutes at a time, you will be able to find the time with a lot less stress, (been there, done that time!)

Remember, plan for this time at first, even if it is only for a few minutes. It is not the quantity of the time but the quality of the time you spend, just . . .letting. . . . . yourself . . . . . .go . . . . and. . . . . .
. . . . .relax . . . .

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Relaxation Takes *PRACTICE*

Before you stress out trying to relax, remember being actively aroused or mentally alert has it's good points as well as the bad and like wise for being relaxed. We all know those individuals who are so laid back they work best in reverse! There is a proper time to be quicker than others. The key is to be able to call upon the proper response when you need it. Knowing when is as important as knowing how.

Starting with the how, everything we do in life takes practice. Think about it, was there ever anything you did really well the first time you tried it? Relaxation, not sleeping or napping mind you, but simply being calm and at peace takes practice as well. So where do you start?

Knowing the difference in feeling between your body's response to high arousal and deep relaxation is the first step. Try these exercises and pay close attention to the different responses.

Hyperventilate by breathing heavily for a few seconds. (Be careful not to overdo, if you start to feel faint, stop.) Close your eyes and note the sensations you feel.

•

Run in place or do exercises for a solid minute or two.

•

Think about something very upsetting or very exciting.

After you do each one of these exercises, stop and really pay close attention to what's happening to your body. If you don't feel as strong a reaction to the last example, remember thinking about emotional states will effect the body physically but not as quickly as exercise.

Ok, so now you're dizzy, out of breathe, excited or worrying yourself silly. Next, you need to experience the opposite of these feelings. Remember you need to know where you are before you know where you need to go. When you can successfully move between your active, aroused state and the calm, relaxed state when you choose to, you will have obtained self mastery.

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✓

Things *not to do* to Relax

The opposite of relaxation is activity, physical activity and mental activity. You may have experienced times when you really would like to relax, and even though you have ceased to be active physically, you just can't turn your brain off. Truly, it is a great deal easier to reach a state of relaxation from simple physical stimulation than from unconscious heightened mental activity.

This is due to the fact mental activity in many instances takes the form of different emotional states causing certain non-voluntary physical changes to take place, including heart rate, blood pressure and muscular tension. You have probably heard about the fight-or-flight response where people have accomplished tremendous acts when under extreme pressure.

These changes occur to give the person an extra push and when the body uses physical action, to fight or run, the increased supply of adrenaline is safely consumed by the body.

However, if your body undergoes these changes on a regular basis, the fight-or-flight response becomes habitual, then dangerous. What seems like an extreme situation, is really quite common in today's society. Think about that person who seems to work best under pressure, that wouldn't be you, would it?

That extra dose of adrenaline can be a secret weapon to help some people feel excited and alive. But be aware, the person who makes high-stress situations repeatedly to create the energy to handle things is usually the same person who hisses back between clenched teeth, "I *am* relaxed" when told to relax! (or don't tell me what to do!)

The way to use up surplus stress is not always best accomplished by throwing your self into some physical activity or those people using fight-or-flight response for energy wouldn't be in such bad situations. And also, it isn't convenient to suddenly jump up and run in place or do jumping jacks instead of arguing with someone. And while choking someone is physical . . . .

The real secret weapon is knowing when to consciously turn off the fight-or-flight response and turn on the slow-down-and- take-a-break response. But knowing this is not doing it!

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Everyday Thanksgiving

Even though I clutch my blanket and growl when the alarm rings each morning,
Thank You, Lord, that I can hear.
There are those who are deaf.

Even though I keep my eyes tightly closed against the morning light as long as possible,
Thank You, Lord, that I can see.
There are many who are blind.

Even though I huddle in my bed and put off the physical effort of rising,
Thank You, Lord, that I have the strength to rise.
There are many who are bedfast.

Even though the first hour of my day is hectic, when socks are lost, toast is burned, tempers are short,
Thank You, Lord, for my family.
There are many who are lonely.

Even though our breakfast table never looks like the pictures in the magazines and the menu is at times unbalanced,
Thank You, Lord, for the food we have.
There are many who are hungry.

Even though the routine of my job is often monotonous,
Thank You, Lord, for the opportunity to work.
There are many who have no job.

Even though I grumble and bemoan my fate from day to day, and wish my circumstances were not quite so modest,
Thank You, Lord, for the gift of life.

Public

A Promise to Myself

I promise, from this day forward:
To accept myself unconditionally
to always love myself and cherish my existence
to always show myself respect
to not demand perfection
to stop putting myself down
to give myself the credit I deserve
to be my own best friend, someone I can depend on
to open my eyes to the beautiful promise in me
to utilize my God-given talent to build inner security
and to make a positive contribution to the world.
because
only if I love myself can I truly love others
only if I respect myself can I respect others
only if I'm open to the specialness in me, can I
genuinely appreciate the uniqueness in others
only if I cherish my own existence, can I
become the person I was meant to be!

Jen Beller

✓

Meditation, like an angel came,
To enlighten his mind,
To liberate his heart,
To immortalize his life.

Sri Chinmoy

Enterprise Zone-Preschool Inclusion Project

Mentor Training

Session #3

Role Play Activities

Scenario #1

- You have a child who you are having difficulties with. Your mentor has come to visit. Please explain to her how you are feeling.

Scenario #2

- The parents, at your protégé's center, are upset that there is a child with a disability in one of the classrooms. Help you protégé manage this crisis.

Scenario #3

- Your protégé has a child with autism participating in the full day program. She needs help. How do you suggest ideas?

Scenario #4

- You find that your protégé is not implementing the strategies that you think would help their children in the classroom. How do you encourage them to do so?

4

Successful Mentor Practices

Objectives:

- Understand how to use conflict resolution skills in the classroom
- Review objective observation techniques
- Discuss how modeling is an excellent educational strategy
- Share trouble shooting ideas and experiences

Materials:

- ✓ "Relaxation toys" such as slinkys, rubber balls, bubbles, silly glasses, etc…
- ✓ Flip chart paper and markers
- ✓ *The Early Childhood Mentoring Curriculum: A Handbook for Mentors* (Bell, Whitebook, & Hnatiuk, 1997).
- ✓ "Suggestions for Observing" (Handout 2-2, MITCH module 3)

Teaching Strategies

I. **Housekeeping** (5 minutes) - Welcome participants and invite them to use the toys that are on the tables at any time during the session.

II. **Icebreakers** (15 minutes) - Have participants share with the class about their most memorable mentor. Have them talk about why the person they chose was such an inspiration and why they valued them so much.

III. **Conflict Resolution** (15 minutes) - Use Unit 6 from *The Early Childhood Mentoring Curriculum: A Handbook for Mentors* (Bell et al., 1997) to review the concepts of conflict resolution. Use the chart on page 84 to discuss how to find solutions for problems with co-workers and others in the classroom environment.

IV. **Observations** (35 minutes) - Distribute the "Suggestions for Observing" handout and use it to discuss objective techniques and the importance of observations when dealing with children who have potential special needs.

V. **Break** (5 minutes -Optional)

VI. **"Modeling" technique** (10 minutes) – With the guidance of Unit 6, pages 80-82 from *The Early Childhood Mentoring Curriculum: A Handbook for*

Mentors (Bell et al., 1997), discuss the effectiveness of modeling as a teaching strategy. Have two volunteers role-play a scene modeling appropriate interactions with parents, protégées and other adults. Stress that mentors can use modeling to help protégées learn successful inclusion practices.

VII. **Discussion** (20 minutes) - Lead participants in a conversation about how to actually implement successful mentoring skills. Explore various ideas on how to put plans into action. Talk with the group on how to stay focused and on task. Discuss the ideas of list- making, goal setting, and information sharing with colleagues. Ask the group to elicit suggestions on successful implementation of mentoring.

VIII. **Troubleshooting** (20 minutes) - Discuss with participants about how to look forward and try to stop undesired actions before they actually happen. Give some ideas to mentors about what types of things they could do to try and problem solve through a situation. Converse as a group different ways to alleviate difficulties and eliminate challenges.

IX. **Conclusion/Wrap-up/Questions and Answers** (10 minutes)

References

Bellm, D., Whitebook, M. & Hnatiuk, P. (1997). *The Early Childhood Mentoring Curriculum, A Handbook for Mentors*. National Center for the Early Childhood Work Force, Washington, D.C.

Molinet-Molina, M. & Estrada-Vidal, R. M. (1990). The Child Who Seems Different: Meeting Special Needs. "In C. F. Abbott & D. M. Fernandez (Eds.), *Mitch Module 3, Model of Interdisciplinary Training for Children with Handicaps: A Series for Caregivers of Infants and Toddlers*. Florida Department of Education. Division of Public Schools. Bureau of Education for Exceptional Students.

Enterprise Zone-Preschool Inclusion Project

Mentor Training

Homework Assignment #4

Session Four Assignment

- Using the "Small Group Time Observation" form, observe a small group and fill out the form using only factual and detailed information.
- Using the "Observing Adult Talk" form, observe a child/teacher conversation and fill out the form using only factual and detailed information.
- Write a two-paragraph paper on the findings you gathered while doing your observations.

Suggestions for Observing

1. Watch the child in many different work and play settings.

2. Observe how the child gets along with other children in small and large groups.

3. Observe how the child responds to adults.

4. Consider cultural factors that may influence the child's behavior.

5. Observe what makes the child happy; what makes the child sad.

6. Observe whether the child acts older than others of the same age.
Observe whether the child acts younger than others of the same age.

7. Watch to see if the child appears:
    - sad
    - tired
    - lethargic
    - stressed
    - oversensitive
    - overactive.

8. Observe changes in the child's behavior at different times of the day.
If changes occur, what seems to cause the change?

9. Watch for clumsiness or lack of coordination.

10. Decide if the child seems to hear and see as well as other youngsters.

11. Observe whether the child seems to learn at the same, a slower, or a faster rate than others.

12. Determine how the child seems to learn best:
    - by watching
    - by doing (touching)
    - by listening.

13. Decide if the child communicates as well as others of the same age.

14. Decide if the child can care for personal needs as well as others of the same age.

15. Determine which methods of discipline work best for the child.

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Module	Hour	Handout
3	2	2

The Enterprise Zone-Preschool Inclusion Project

Evaluations

Enterprise Zone-Preschool Inclusion Project
Mentor Component
Evaluation

Today's session

Not productive 1 2 3 4 5 Very Productive

1. **I came expecting…**

2. **I got…**

3. **What I know now that I didn't know before…**

4. **Three practices I may consider changing in my program, home care, and classroom as a result of what I learned today…**

University of Miami- Department of Pediatrics

EZ-Preschool Inclusion Project

Mentor's Questionnaire

The following questions are to be addressed as soon as you complete each session with your protégé. Whenever possible, do not let time go by between the session and filling out this form. Remember that the sooner you complete this, the better the chances to be more accurate in your report. Use the back of the page should you need extra space. Thanks for your cooperation.

1) In a few words, describe what type of assistance was requested from you in this session?

2) In your own words, would you describe this session as positive, negative or neutral? Please elaborate on your response.

3) How effective do you find the mentor model? Do you believe it is useful or helpful in helping teachers work with children with disabilities?

4) What aspects of the mentor-protégé model would you change? How would you improve it to maximize the model's effectiveness?

5) What was the most important thing you learned from your protégé? And from being a mentor?

6) In a few words, describe your level of satisfaction with the support you received from the project coordinator and or the research component of the project. Would you have liked things done differently? If so, please explain.

Thank you for your support!! ~~Should you have any questions~~ concerning this form, please contact Dr. Marcelo Castro at 305-243-3097.

The Enterprise Zone-Preschool Inclusion Project

Mentor Support Meetings

Mentor Support Groups

In addition to the mentor training sessions and mentoring appointments the EZ-PIP project also held mentor support groups. The project director assisted, however the mentors ran these groups. The mentors chose a variety of topics to discuss at each session. The topics to be discussed during these meetings were chosen by the participants. Participants were encouraged to bring articles from newspapers, online resources and other resources that interested them to share at the group meetings. There was a great deal of interest in child abuse and reporting requirements; consequently for one of these meetings the project director brought information on child abuse. Following is a sample list of topics brought by the mentors to the support meetings:

- The Learning Disability Resource, Homework Central, www.noswest. Com
- Inclusion articles and handouts from various sources
- Laws and regulations from the American with Disabilities Act (ADA)
- Child Abuse General Information
- General information on children with special needs
- Information on community resources
- And many more...

Enterprise Zone- Preschool Inclusion Project

MENTORING SUPPORT MEETING

November 17, 1997

Greetings/ Introductions/ Welcome

NAEYC Conference Review

- EZ-PIP Project Update
    - Research Instruments-Scot Liepack
    - Family childcare homes-very active support-Michele Scott
    - Introduced the Family childcare flyer
    - Homestead School Participant list-Faye Farnsworth
    - Discuss EZ-PIP 89 page brochure
- Adoption of minutes
- Mentoring Component Update Information-Rhonda Conway
- Open Discussion/ Q&A
- Introduce "The Tulip" newsletter
- Distribute Calendar
- Next Meeting

Enterprise Zone-Preschool Inclusion Project (EZ-PIP)
Second Mentor Planning Meeting

Monday, November 17, 1997
1:00 p.m.-3:00 p.m.
Bet Shira's Library; 7500 S. W. 120 Street; Miami, FL 33156
Telephone: 238-2606/5706

Mailman Center for Child Development:

Susan Gold, Ed., Principal Investigator, PIP and EZ-PIP;
Sheena Benjamin-Wise, Project Manager, PIP (in absentia);
Faye Farnsworth, Project Manager, EZ-PIP/Child Care Centers (CCCs);
Michele Scott, Project Manager, EZ-PIP, Family Child Care Homes (FCCHs)
Scot Liepack, Research Coordinator, PIP and EZ-PIP (in absentia)
Elizabeth Otto, Research Assistant, EZ-PIP
Louise Marcelin, Research Assistant EZ-PIP

Mentors:

Claudia Gray (Center Director, Elizabeth Curtis CCC)
Peggy Johnson (Center Director, Homestead Family-YMCA)
Susan Rosendahl (Center Director, UM*Canterbury) (in absentia)
Gladys Montes (Director, Catholic Community Services) (in absentia)
Yolanda Borroto (Center Director, South Miami Lutheran) (in absentia)
Rosemary Moreno (Center Director, REM Learning Center) (in absentia)
Terri Reynolds (Teacher, Bet Shira CCC)
Nancy Feldman (Teacher, formerly with Brickell Christian)

Consultants:

Rhonda Conway, (Conway & Associates, Inc.), Mentor Consultant
Pat Donovan, (ARC) Special Instruction Consultant (in absentia)
Carol Byrd, (UCP) Special Instruction Consultant (in absentia)

TOPICS OF DISCUSSION

I. Introductions and Welcome

Susan Gold began the meeting by introducing our two new research assistants, Elizabeth Otto and Louise Marcelin.

Joined by our host (Judi Gampel, director, Bet Shira) we each introduced ourselves. Judi, having just returned from the National Association for the Education of Young Children's (NAEYC) annual conference in Anaheim, CA., shared an inter-office staff memo highlighting the sessions she attended (three on inclusion). She provided a handout on the "Early Childhood Staff Working Together to Create Inclusive Classrooms: A Learning Team Approach" by Penny Wald of George Washington University and Holly Blum of the Fairfax, VA, County Public Schools. Judi has graciously offered to put together a presentation highlighting the conference's session she attended.

Before turning the meeting over the Rhonda Conway, Susan Gold gave an update on the rest of the EZ-PIP project:

She and Scot Liepack are preparing for their DEC conference presentation in New Orleans, November 22, 1997.

After the DEC conference, Scot will focus his energies on the UM Internal Review Board's (IRB) review of our research instruments. Faye Farnsworth, in collaboration with Sheena Benjamin-Wise, Elizabeth Otto and Louise Marcelin, will begin developing the 60 to 64 additional pilot pre/post questions for IRB review December 3 and 4.

Michelle D. Scott, is meeting with Metro-Dade Office of Community and Economic Development's (OCED) Ignacious De La Campo's assistant, Tuesday, November 18, 1997, to gain active support for the Family Child Care Homes (FCCH) component of the EZ-PIP grant.

Michelle has prepared a letter of intent to the Dade Foundation and is preparing two proposals (state and national conferences).

Additionally, she presented the first draft of the EZ-PIP/FCCH one-page flyer for distribution in December.

Faye Farnsworth gave an update on the nine participating child care centers in the Homestead area. An on-site visit to each center is pending. Faye will confer with Peggy Johnson to begin scheduling training dates (tentatively for the end of January or beginning of February). Enthusiasm is growing among early childhood educators for training to begin. Simultaneously, we will begin English-speaking training at our North Creole Site (YWCA) at the request of their center director. The "Y" is a PIP site and we need to keep data collection free from contamination; so we will go outside the Homestead enterprise zone area in Year 1. Additionally, Claudia Gray advised that Sparks Day Care and Kindergarten in North Dade is interested.

The first draft of the 8-page EZ-PIP/CCC brochure was discussed. A first read looks very positive and the brochure is off for committee review.

II. Adoption of Minutes

Rhonda Conway made two corrections to the October 15 minutes:

Page 2, IV. Recruitment of Proteges, No. 3: "leadership training for mentors is required before pairing occurs" and

Page 2, V. Training: Who? When? Where? First paragraph, second sentence: "It is proposed mentors receive a modest stipend to defray their out-of-pocket costs...."

III. Mentoring Component

Rhonda Conway led the discussion by submitting a draft of the suggested protégé teacher application packet which will be adapted for the center director mentor packet. The packet is being reviewed.

Rhonda brought up the subject of marketing for mentors. Susan Gold discussed the grant's budget limitations where there is funding for four mentors in each of the four years of the grant so that marketing for more mentors at this point, without additional funds, was not a real concern.

(The group put forth recommendations for mentor funding sources such as the South Dade Women's Council of Realtors, the National Council of Jewish Women, Resources for Children [Dr. Wil Blechman's organization], the Kellogg Foundation and Pillsbury.)

Rhonda highlighted the following areas of consideration:

1. How many center directors and teachers can each center director mentor and teacher mentor handle?

2. Time availability of mentors and protégés. The current budget allows stipends for four mentors at three hours each per week.

3. A mentor survey will include questions such as where they live and work. [Note: Rhonda will coordinate with Scot Liepack on any data collection.]

4. For the FCCH component, Michelle Scott will be the mentor to all FCCH providers.

5. Urged getting center directors totally invested in mentoring program to effect the "trickle down" effect. Strong leadership evokes a strong following.

IV. Open Discussion

Terri Reynolds reports that since our October 15 meeting, three teachers (to her surprise and delight) approached her asking for inclusion support. She found Rhonda's handouts from that meeting to be helpful in answering their questions.

Peggy Johnson's staff is anxiously awaiting inclusion training. And Claudia Grey is experiencing similar positive feedback.

Susan Gold, in looking back at the old data from PREP, noted when center directors came to meetings, there was higher teacher attendance. Further, it took about one and a half years after initial inclusion training that significant positive changes in the centers were noted.

Susan reminded the group on the importance of center director mentors not mentoring their teachers due to the supervisory nature of their positions. She also encouraged the evolution of cross-school mentoring.

Hot-off-the-press copies of our newsletter, **The TULIP**, were distributed. Susan will be preparing an article for the second edition on mentoring.

Invited to this meeting as new center director mentors were Rosemary Moreno, Gladys Montes and Yolanda Borroto. Their schedules did not permit attendance at today's meeting. Pat Donovan and Carol Byrd, our Special Instruction consultants, will be present once our mentor training sessions begin in January 1998.

Susan debriefed the group on her October visit to the White House announcing the Clinton Administration's initiative on early childhood development.

On November 20 there is an open meeting at *The Miami Herald's* office where Governor Lawton Chiles' initiative on early childhood education will be put forth by David Lawrence, publisher. A discussion of readiness for school will bring forth a stinging indictment on the woeful lack of support to the early childhood education field by way of prestige and wages.

The Dade County Public School Board meets on December 10 at 10 a.m. at their 1500 Biscayne Offices to discuss early childhood education issues--Goal 1: Are children ready to learn? This is a long-term proposition being considered by this newly appointed board.

V. Calendar of Eight Mentor Training Sessions

1. Monday, January 12, 1998
9:30a to 1:30p
(first meeting--4 hours)
Bet Shira's Library*

2. Monday, January 26, 1998
1:00p to 3:00p
Bet Shira's Library*

3. Monday, February 9, 1998
1:00p to 3:00p
Bet Shira's Library*

4. Monday, February 23, 1998
1:00p to 3:00p
Bet Shira's Library*

5. Monday, March 9, 1998
1:00p to 3:00p
Bet Shira's Library*

6. Monday, March 23, 1998
1:00p to 3:00p
Bet Shira's Library*

7. Monday, April 13, 1998
1:00p to 3:00p
(Place of Meeting to be Confirmed)
YWCA-Gerry Sweet Center*; 351 N.W. 5th Street
377-9922
OR
UM Mailman Center for Child Development*
1601 N.W. 12th Avenue; 4th Floor Conference Room
243-6624

8. Monday, April 27, 1998
9:30a to 1:30p
(final meeting--4 hours)
Bet Shira's Library*

*It was suggested we have a "bring-your-brown bag" lunch.

Distribution of Minutes to:

MCCD Staff: Susan Gold, Ed.D.
Sheena Benjamin-Wise
Faye Farnsworth
Michele D. Scott
Scot Liepack
Elizabeth Otto
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Peggy Johnson, FAX 305-248-5193
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Rosemary Moreno, FAX 305-235-0007
Terri Reynolds, FAX 305-238-5706
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Pat Donovan, FAX 754-9223
Carol Byrd, FAX 325-1313

File: MCCD:PIP (Year 3) 11/17/97 Mentor Minutes; and
MCCD:EZ-PIP/CCC & EZ-PIP/FCCH (Year 1) 11/17/97 Mentor Minutes ✓

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The Enterprise Zone-Preschool Inclusion Project

Resources

INGREDIENTS OF A SUCCESSFUL MENTORING PROGRAM

Chris Cross
Resource and Development Coordinator
Florida Children's Forum

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Mentoring Programs in the Family Child Care Profession

Mentors

"A mentor, historically and traditionally defined, is an older, more experienced person who is committed to helping a younger, less experienced person become prepared for all aspects of life. (Odell, 1990)

In early childhood, the term mentoring generally means "a early childhood teacher or provider who is concerned not only with how children grow and learn, but in gaining skills to help other adults become more effective practitioners." (Mentoring in Early Care and Education – The National Center for the Early Childhood Work Force). Often used interchangeably with terms like coaching or counseling, tutoring and guiding, the basic term "mentor" assumes that the teacher or provider has worked in the field for a period of time and has received some education and training (although this will vary from program to program)

As more and more providers enter the field with little or no training (i.e. Caring for Kids Initiative) the demand skyrockets for skilled mentors who can help them. Mentoring programs help providers by providing them with the skills they need, and by establishing a viable career path that will provide them with financial and professional incentives to stay in the classroom.

Mentoring training programs create a space for experienced teachers and providers to gain the adult training skills necessary for success in heir current role as on-the-job trainings for newly recruited providers, many of whom have minimal backgrounds in child development

Equally important, mentor programs create a new step in the early childhood career progression, allowing a provider to advance professionally while continuing to educate and teach children directly.

Benefits for Mentors:

1. Growth - defining and redefining their own beliefs and actions (seeing it through the eyes of their protégées)
2. Recognition - confers a certain "expert" designation
3. Experience-Enhancing Roles - requiring the acquisition of new knowledge and skills to assume new roles
4. Networking - helping to illuminate the cycle of isolation

What do Mentors DO?

Protect, sponsor, promote and open doors; teach, coach, challenge, consults, advise and counsel; provide a positive role model; problem solve and move on, leading others to more sophisticated stages of concern and cognitive development; guide your partners in practice-along a path that creates, rather than prohibits, the potential for excellence in teaching

Mentoring Programs

Mentoring programs are based on the notion that experienced providers and teachers are more readily trained in the field if they receive advanced education, salary enhancement, and the opportunity to share their expertise with inexperienced caregivers.

It is important to note that not all mentoring programs are alike - nor do they have the same goals. However, they all generally are committed to three basic common goals:

- ⇒ retaining experienced, skilled providers by providing financial incentives and recognition of their contribution and skills;
- ⇒ providing professional development opportunities for mentors;
- ⇒ helping the new and inexperienced provider to become better caregivers

Some of the general principles that can serve to guide program development should be:

- ⇒ responsive to the developmental needs of those they serve;
- ⇒ support in nature
- ⇒ forums for improving connections between mentors and protégées
- ⇒ learning systems that help to improve the overall health of the profession

Mentor programs:

- ⇒ challenge the perception of child care as unskilled work
- ⇒ they establish an incentive for caregivers to continue in the field by providing them with new opportunities for leadership development
- ⇒ strengthen the voice of the profession in trying to upgrade child care services
- ⇒ are truly collaborative efforts
- ⇒ can greatly enhance the consistency and quality of the services that children and families receive each day

Key Considerations in the Development of Mentor Programs

The Initial Phase:

Players:

It is critical to have a diverse and representative group of partners committed to it from the beginning. This creates a sense of ownership and responsibility toward the program. Ideas on who could serve on this committee:

1. Providers
2. Association leaders instructors and administrators from local colleges
3. Child care trainers
4. Child care resource and referral agencies
5. School district representatives
6. Child care advocates
7. Foundations
8. Education Specialists

9. Government representatives
10. Private sector corporations who support child care

While this may be hard at first (to find dedicated and motivated members) it is important from the very beginning to diversify as much as possible. Remember that it is important that the planning group reflect racial, ethnic, economic and cultural diversity - addressing barriers as needed (i.e. transportation, lack of child care, times and locations).

The Planning Process:

This phase will require substantial deliberation. Many groups have spent six months to a year designing their programs, beginning with articulating a vision and a set of goals. These are essential for recruiting members to the planning group, but may need to be revised as new members give their input. Because mentoring might mean many different things to different people, early planning may also require some careful definition of terms in order to avoid misunderstandings - currently and in the future.

Funding:

Before you can decide what funding you need to operate a program, you will need to consider all anticipated costs. Naturally this cost will change over time due to many factors, however, it is almost impossible to get a funder to cover additional costs at a later date.

The most obvious funding source will be through block grants and/or private foundation grants. However, by working with established institutions such as colleges in planning the program, program developers have also received in-kind donations of time or other resources, including information about access to other funding sources.

The Implementation Phase

Who Should be a Mentor? Who should be a Protégé?

While the criteria is usually agreed upon by work groups, application of the program can cause many challenges.

Mentors:

⇒ a sound background in early childhood education including an understanding of age-appropriate activities for children
⇒ an articulated, knowledge-based philosophy about what constitutes high quality early care and education services
⇒ a certain minimum classroom or family child care home experience (1-5 years generally)
⇒ good interpersonal skills for working with adults
⇒ time and energy to make a commitment to the mentoring program

Protégés:

⇒ are usually employed in the field, committed and motivated to assume greater responsibility and supported by their family to participate in the program

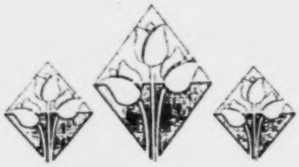
Supports to Ensure Mentor and Protégé Participation

Mentoring Programs require an additional investment of time and energy beyond the demand of already challenging child care jobs. Without adequate support, mentors and protégés will be unable to complete their training or follow through in practice with what they have learned. Participants identified a number of interventions to aid mentors and protégés:

⇒ Orientation
⇒ Recognition
⇒ Financial Reward
⇒ Realistic Requirements
⇒ Release Time and Substitutes
⇒ Family Involvement
⇒ Field Instructors
⇒ Ongoing Support Structure
⇒ Building the Mentor Voice

Common Challenges to Successful Program Operation

⇒ Mentoring Versus Supervision
⇒ Community Relations
⇒ Job Turnover
⇒ Documenting Program Achievements



The Enterprise Zone-Preschool Inclusion Project

Sample Certificate

This certifies that

has successfully completed 10 hours of mentor leadership training

Sponsored by

Enterprise Zone - Preschool Inclusion Project

Funded by the U.S. Department of Education, Office of Special Education Programs

University of Miami Mailman Center for Child Development

A University Affiliated Program

1999

XXXXXX, Assistant Project Manager

XXXXX, Project Director

The Enterprise Zone-Preschool Inclusion Project

A Training and Resource Manual for Inclusion in Childcare

Book 4: Findings and Accomplishments

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A helpful tool for Early Care & Educational Professionals

EC 309364

The Enterprise Zone-Preschool Inclusion Project

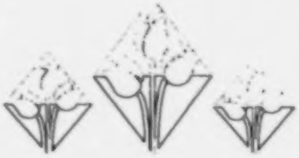
A Training and Resource Manual for Inclusion in Childcare

University of Miami

School of Medicine
Mailman Center for Child Development
Miami, Florida

Susan Gold, Ed.D., Principal Investigator

The Enterprise-Zone Preschool Inclusion Project was funded by
The U.S. Department of Education Office of Special Education grant
#H024B70071



The Enterprise Zone-Preschool Inclusion Project

Book 4
Findings and Accomplishments

Book 4: FINDINGS AND ACCOMPLISHMENTS

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- **Focus on Inclusion PowerPoint Presentation**
- **Focus Group Poster Presentation**
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7 Inclusion Assistance Grant

8 Meetings

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The Enterprise Zone-Preschool Inclusion Project

Published Articles

SUPPORTERS

Florida Department of Education
Kiwanis, International
Florida Department of Children & Families
State of Florida Department of Labor
Florida Children's Forum
Florida Diagnostic and Learning Resources System/South
Miami-Dade County Public School System
Miami-Dade Association of Child Care Programs, Inc.
Community Committee for Developmental Handicaps
Family Central, Inc.
Miami-Dade Child Development Services
Parent to Parent of Miami, Inc.
YMCA & YWCA
Miami-Dade Community College
Redlands Christian Migrant Association
Metro-Dade Office of Community and
Economic Development
Community Council for Young Children with
Special Needs (CCYCSN)

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Enterprise Zone
Preschool Inclusion Project

Promoting the Inclusion of Children with Special Needs Into Quality Child Care Settings

A Message To Early Childhood Educators Who Work With Or Want To Work With Children With Special Needs

If you are a childcare provider for a child with a disability and interested in information to help you better serve children in an inclusive early childhood setting. this is designed for you.

This pamphlet was supported by U.S. Department of Education
Office of Special Education Programs grant #H024B70071
to the UM/Mailman Center for Child Development

Q&A

What Is Inclusion?

Inclusion is the practice of providing children with disabilities and/or special needs the opportunity to learn together with other children in their neighborhoods in a stimulating, natural environment encouraging developmentally appropriate practices.

How do I include a child with a disability or special needs in my classroom?

It is estimated that one out of every ten children has a special need. Chances are you have or will have a child with special needs in your classroom. Since a Center cannot simply refuse to enroll a child based on a disability (according to the Americans with Disabilities Act of 1990), you may have concerns about resources and training to help support you, the child with special needs in your classroom, and the child's parents. We encourage you to contact us for information on how to include children with special needs into your programs.

Will the other children accept a child with a special need?

Children are very accepting. When adults provide a warm and accepting environment, the children, in turn, model that behavior. Rejection of children with special needs by children without disabilities is uncommon. With guidance and positive role modeling, children without disabilities show sensitivity to the needs of others.

Can a child receive therapies in my childcare setting?

The answer is both yes and no. It depends on at least one or more of the following: the age of the child; whether the child is entitled to services under the federal law (Individuals with Disabilities Education Act); whether the child care provider is willing to allow therapists to come into the center; and whether parents' private insurance will pay for therapies. It also depends on the availability of therapists in your community.

How will I, as an early childh ɘducator, involve parents of a child with special needs in the classroom?

Children achieve more when their parents are actively involved in their development and education. Parents should be provided with opportunities to be involved in all aspects of their child's program. Early childhood educators and parents need each other's cooperation and support in order to obtain the best possible results for children. Our project can help you provide parent involvement opportunities.

Do I have to keep the diagnosis of a child with special needs confidential?

All centers should have a policy concerning confidentiality. Child care settings with successful inclusion programs understand that every child has varying abilities and that labeling is counterproductive. The center staff is mandated by law to keep a child's medical diagnosis confidential. However, some special needs are self-evident. **It is the parents' decision when and how much information is shared with other early childhood educators and parents.**

How will I benefit by participating in EZ-PIP?

Staff development opportunities are available for participants..
Training session topics are:

- ***Introduction to the Project and the Philosophy of Inclusion***
- ***The Amazing Developing Brain***
- ***Social Interaction and Teamwork***
- ***The Child Who Seems Different: Meeting Special Needs***
- ***Using a Screening Instrument Part I and Part 2***
- ***Adapting the Classroom for Children with Special Needs***
- ***Behavior Management***
- ***Intellectual Development: What You Can Do to Help***
- ***Speech and Language Development***
- ***Universal Precautions: Medication Administration and Seizure Management***
- ***The Next Step: Professionalism and Advocacy***

"Children Are More Alike Than Different"

Young children should learn together. Children with special needs should have the opportunity to attend quality schools with their peers in their own neighborhoods. Children without special needs benefit by learning how to interact with everyone regardless of their abilities. Society benefits by raising a generation of sensitive and capable individuals. As an early childhood educator, you play a vital role in making inclusion the vehicle that makes all this possible.

Goals & Objecti

The University of Miami Mailman Center for Child Development, in partnership with the Metro-Dade Office of Community and Economic Development, is committed to expanding opportunities for children with special needs to attend quality early childhood development programs in their neighborhoods.

Six objectives of EZ-PIP are to:

1. Expand the number of inclusive family child care homes and child care centers in three of Dade County's Enterprise Zones
2. Increase the number of children with disabilities who attend quality inclusive child care settings
3. Increase the awareness and competencies of child care providers to serve children with disabilities by providing group and individual training and mentoring
4. Provide individualized educational services and assessments for children with disabilities
5. Work with families and facilitate cooperation between existing systems of service delivery for children
6. Evaluate, replicate and disseminate the EZ-PIP model benefiting future generations

The TOTAL Training Model Strategy

The vehicle for accomplishing this goal will be the TOTAL training model which offers (12) sessions designed for early childhood educators. These sessions will teach recent advances in serving children with special needs and their families. Mentors will be your encouragers, supporters, guides, advisors and confidants.

Training
Observe inclusion classrooms
Talk continuously with mentor
Apply knowledge to classrooms
Learn on your own

This project is dedicated to continuing the expansion of opportunities for young children with disabilities or special needs to attend quality child care centers and family child care home settings throughout Miami-Dade County, Florida. The staff of this project believe in the philosophy of INCLUSION, which is the practice of providing children with disabilities and/or special needs the opportunity to learn with other children in a natural environment which encourages growth and development.

Published Articles

- Craig, S., Haggart, A., Gold, S., & Hull, K. (2000). Expanding the circle of inclusion: The child care director's role. *Young Exceptional Children*, Monograph series No. 2, 27-36.
- Davies, F. (1997). Day Care for Special Children. *The Miami Herald*.
- Gold, S. & Abbott, C. (1989). A dilemma for preschool teachers: when to refer. *Dimensions*, January, 8-11.
- Gold, S. & Abbott, C. (1991). Conferring with parents when you're concerned that their child needs special services. *Young Children*, May, 10-14.
- Gold, S. (1999/2000). Including Young Children with Special Needs in Early Childhood Programs: Where is Florida Headed? *Children Our Concern*, Winter, 23-29.
- Gold, S., Liepack, S., Scott, M., & Benjamin-Wise, S. (1997/1998). If you offer inclusion training, they will come! *Children Our Concern*, Winter, 24-26.
- Gold, S., Liepack, S., Scott, M., & Benjamin-Wise, S. (1999). Creating inclusive classrooms: A report from the field. *Young Exceptional Children*, 2-5.

Expanding the Circle of Inclusion

The Child Care Director's Role

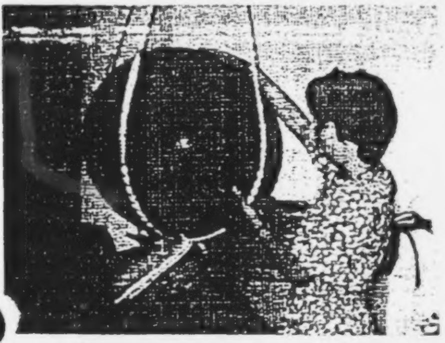
Susan Craig, Ph.D., AGH Associates, Inc.
Ann Haggart, Ed.M., AGH Associates, Inc.
Susan Gold, Ed.D., Mailman Center for Child Development
Karla Hull, Ph.D., Associate Professor, College of Education
Valdosta State University

Introduction

Despite federal and state laws that require services in the least restrictive environment, as well as research which supports its benefits, broad based implementation of inclusive child care continues to elude us (Brown, 1997). Early interventionists trained to address the needs of infants and toddlers with disabilities within formal, planned learning opportunities struggle with the more informal, open-ended structure of center-based child care programs (Bruder & Dunst, 1999). Child care directors, although aware of the Americans with Disabilities mandate to make both public and private child care programs accessible to children with disabilities, are not well informed about the need for child care among the families of young children with disabilities (Craig, 1996; Craig & Haggart, 1994). As a result, only a small percentage of families seeking inclusive child care are able to find it (Devore & Hanley-Maxwell, 2000; Fewell, 1993; Gold, 2000; Guralnick, 2000; Landis, 1992).

Until recently, most efforts to promote inclusive child care have primarily focused on child care *providers*. Since providers are responsible for the day-to-day care of children, training on atypical development and the accommodations necessary for caring for children with disabilities is directed at them. While this type of training is important, it tends to ignore the important role child care *directors* play in setting program policies. Child care directors are in the position of either encouraging or discouraging the enrollment of children with disabilities. They represent a previously untapped resource for solving the problem of inclusive child care.

Much like a principal of a school, the child care director's vision inspires the kind of care available at a center. Research on educational change and effectiveness consistently points to the role of the program administrator as having a critical influence on making programmatic and policy changes (Berman & McLaughlin 1978; Fullan, 1991; Rutter et al., 1979; Sergiovanni, 1994). In fact, program level administrators are the people "most likely to be in a position to shape the organizational conditions necessary for success, such as the development of shared goals, collaborative work structures and climates, and procedures for monitoring results" (Fullan, 1991, p. 76). Child care directors determine center policies, as well as procedures for enrollment and dismissal (Bloom, 1988). They are responsible for training providers, setting program standards, and modeling quality care for other employees (Bloom & Sheere, 1992). Given the scope of their responsibility and power, collaboration between early intervention and child care directors is an important step in creating center policies which encourage the participation of young children with disabilities.



> *You have to start with the directors. We learned that first hand. There was a statewide training for providers ... they went back to their centers and many were not allowed to practice what they had learned because the director didn't have the same information or philosophy. (Child Care Director, Morgantown, WV, 1998)*
>
> *The directors are the ones who ultimately allow us access to their center, so it is essential that we get them on board and develop positive relationships with them. (Early Interventionist, Temple, TX, 1998)*

Getting Directors on Board

For the past several years, the authors have worked with the directors of 52 child care programs in Alabama, Massachusetts, Maryland, New Hampshire, Texas, West Virginia, and the American Virgin Islands through federally funded model demonstration and outreach projects. The project's goal is to provide Part C coordinators in each participating state with an easily replicated model for partnering with child care directors to create accessible child care options for infants and toddlers with disabilities. Easy replication was assured through the use of inexpensive, self-paced training materials, along with the state Part C's financial commitment to support the collaboration between early intervention and the child care community.

All of the participating project child care directors attended 24 hours of training on inclusion and revised their programs policies and procedures to reflect a commitment to inclusive child care. The majority of the directors worked with local Part C personnel to complete an additional 30 hours of inclusion activities. At the conclusion of these training activities the directors and Part C personnel took part in individual telephone interviews conducted by a professional who was not associated with the training. The interviews were designed to assist in evaluating the quality of training offered to the directors and the impact of this training on the staff and children in their programs. Excerpts from the interviews appear throughout the text.

The directors were overwhelmingly supportive of the training. Now firmly committed to inclusive child care, the child care directors offer Part C early intervention programs the following suggestions:

Define Child Care's Role

Enthusiasm for inclusive child care grows as directors learn to appreciate the contribution their programs can make to children with disabilities and their families. Be sure to take every opportunity to let child care directors know what a vital resource they can be. Recognize the important role personal experience plays in making a commitment to inclusive child care. Reach out to the child care directors in your community and encourage them to meet with other directors who are already enrolling infants and toddlers with disabilities.

> *I had my misgivings in the beginning, I'll admit it. But I had some providers willing to "give it a go," so I decided to try it. We enrolled several children with disabilities. And it was amazing. The providers started coming to me saying "You've got to see Germain!" "You won't believe what Jorge is doing!" The one that really stands out in my mind is a little boy with spina bifida. When he enrolled he could neither walk or talk. But now he can walk. He dances and sings. It's just incredible to be a part of something like this. (Child Care Director, Maryland, 1993)*

Let directors know that you value their years of experience with children. Scaffold new information about the care of infants and toddlers with disabilities onto what they already know. Support their efforts to link the need for inclusive child care to other beliefs they hold about the best program for children in their care.

> *After listening to how age appropriate routines could help a child with disabilities, I went back to my center and changed the placements of two of our children. We had kept both children in the infant room even though they were older. We were worried about them being with older children before they had learned how to walk. But in my heart, it didn't feel right. I knew those children could do more than we were asking them to. So when I heard about the importance of age appropriate placements, I got my courage up. And it worked. Those children are doing just fine. (Child Care Director, Waco, TX, 1999)*

Recognize the efforts some child care directors have already made to individualize care to meet the needs of the families they serve. If a family has several children already enrolled, it is not unusual for the director to take a sibling born with a disability. Praise the directors who individualize care for children with special needs. Encourage them to share their strategies for helping providers accommodate to these children.

> *We came to change our minds and what we were doing as we began to see that children with disabilities could be successful in our programs. (Child Care Director, Massachusetts, 1998)*

> *I learned how narrow minded I was about ... incorporating these children into the group environment. I never realized how easy it would be to accommodate and make someone with special needs a part of my center. (Child Care Director, Katy, TX, 1999)*

Link Inclusion to Other Efforts at Promoting Quality Care.

All child care directors are concerned with improving the quality of care in their centers. They need to know how inclusive child care can support their efforts to promote quality care. Approach collaboration with early intervention as a way for directors to promote best practices for all children. For example, encourage early intervention staff to use their time to build the capacity of classroom staff to address the language and motor needs of all children enrolled at the center. Rather than discussing child development within the paradigm of clinical milestones, show directors how the early intervention staff coming into their centers can use their knowledge to help classroom staff create and sustain a developmentally appropriate curriculum. Rather than emphasizing the differences between children with disabilities and their typical peers, scaffold information about disabilities onto existing staff competencies and knowledge base.

> *I have learned how to approach child care staff differently. I now look at what they are doing and try to find ways to modify these(activities). I have learned to ... work with their styles rather than impose my own. (Early Interventionist, Temple, TX, 1998)*

Use the Incentives of Staff Training, Funding Options

Child care directors are always looking for ways to fund staff training. This is an area where early intervention can really help child care achieve its goals. Part C coordinators working with this project designated regional service coordinators to serve as "EI Bridges" to local child care programs. Time to collaborate with the directors and assist them in training their providers became one of the services Part C offered to child care through the EI Bridge.

Other funding options you may want to discuss with directors include Child Development Block Grant monies or local charities which support education. Many states now require providers to complete Child Development Associate (CDA) training. Find out who offers that training in your community and offer to co-teach some of the sessions, supplementing the required content with applications for children with disabilities.

> *Discussing financial concerns with early intervention and finding out about alternative funding streams was very helpful. (Child Care Director, West Virginia, 1998)*

Supporting Directors to Stay Involved

Develop Relationships

The shift to inclusive child care involves a process of systemic change for both child care and early intervention. Since the process is difficult for everyone, it is important that the professionals involved in it have the support of one another. To achieve this, the child care directors we worked with recommend that local child care and early intervention programs create a structure for ongoing collaboration. For some programs this might be a monthly brown bag lunch session where common concerns are discussed and common resources shared. For others, the local AEYC chapter could create a subcommittee that serves as a "watch dog" group, which monitors local efforts to support inclusive care. Regardless of the format it takes, the relationship forged between child care directors and early intervention needs to be characterized by respect, mutuality, and a formal system of communication which keeps the vision of inclusion alive.

> *We have to work hard to build a relationship. I think the early intervention folks thought that child care providers weren't professional enough. They were very territorial in the beginning. However, our partnership is a natural one, once we get past the prejudices. EI has a great rapport with families and so do we. (Child Care Director, Massachusetts, 1998)*

Point out Potential Problems

Commitment to inclusive child care requires directors to carefully review program policies and procedures. This is important both in terms of eliminating expectations of behavior or placement, which discriminate against children with disabilities, as well as creating procedures that facilitate these children's smooth enrollment and participation.

Most policies are just as applicable to children with disabilities as they are to more typical peers. These include safety plans which specify procedures for emergency evacuation and regularly scheduled environmental audits to make sure that play areas meet standards for the children's ages and activity levels.

Accommodations for children with disabilities may simply be a more stringent implementation of these rules or minor adjustments based on child specific needs. For example, a four-year-old child with a developmental disability may continue to display mouthing behaviors more common among two-year olds. Strict adherence to the Universal Health Precautions would be important in that four-year old's classroom.

There are, however, some procedures that unintentionally limit the participation of children with disabilities. Rules which prohibit bringing food from home limit the participation of children on special diets; acquisition of certain developmental milestones as a criteria for moving into an age appropriate group is a problem for children who will never be toilet trained or able to walk; dismissal for behavior at the discretion of the director reduces the possibility of working with the family and early intervention provider to implement behavior plans addressing a child's specific problems.

Offer to review a center's policies to identify areas of concern. Suggest ways of rewriting, which make the policies more inclusive. For example, suggest that a statement giving the director the right to dismiss children for behavior be replaced with "when appropriate, the director will meet with the child's parents and a member of his early intervention team to develop and implement a behavior management plan which will help him participate successfully in the center's program." Qualify restrictions about bringing food from home with a statement such as "No food can be brought from home, unless the child has dietary restrictions which require it."

> *We always had a policy about not moving children into the next classroom, like preschool, until they were potty trained and could walk. (Now I know) that some of them may never be potty trained or walk but that they still belong in age appropriate classrooms. We changed the policy and it is working fine. And for some of the children who weren't potty trained, just being with other children who are potty trained has taught/motivated them to get trained. Now they move on with their peers and it makes a great difference. (Child Care Director, Morgantown, WV, 1998)*

> *I think one of the biggest changes for them (directors) was being asked to put children with disabilities into classrooms by chronological age rather than developmental age classrooms. This was a big change ... but they are doing it. (Early Interventionist, Waco, TX, 1998)*

A program policy which requires a visit by the parent and child prior to the first day of attendance is a good way to avoid a situation where a child with disabilities will suddenly show up without any opportunity for the necessary training and/or accommodations to occur. Help directors see that this type of policy gives them time to meet with the family and other members of the IFSP team to make necessary accommodations and schedule necessary training prior to the child's first day.

Waiting lists are another issue to think about as directors move to inclusive care. Some centers find that a dual waiting list, one for children with disabilities, one for children with typical developmental expectations, is an equitable way to provide spaces for all children, while at the same time maintaining an appropriate ratio of children with and without disabilities throughout the center. As in the case of school placements, most child care programs find that following the principle of natural proportions is the best way to maintain successful inclusion. That is, directors accept any child with a disability who is a natural part of the "neighborhood, zone, or district from which the ... (center) draws its ... (children)" (Stainbeck, Stainbeck, & Jackson 1992, p. 13).

Active Recruitment

Let child care directors know what they can do to make the families of children with disabilities feel welcome at their centers. Generic nondiscrimination statements are not enough. Parents need additional reassurance that the center is prepared to offer the support needed for a child with significant disabilities (MacTavish, 1995).

Some directors find asking questions about disabilities right on the enrollment form sets the right tone. For example, "Does your child have a disability or a special need which may require some accommodations to child care activities? If so, please describe so that we can make our program accessible to your child." "Does your child have an IFSP? If so, who is the contact person (name and phone number—release of information is also needed)."

Brochures and enrollment forms should state: "Our center welcomes children with disabilities. In order to properly care for your child we might need additional information or help with making sure we have the support we need. If your child has a disability, please arrange to speak to the director so that we can move the enrollment process quickly along." Statements and procedures like these help the director balance the need to make sure that the child is enrolled in a timely manner with the need for baseline information/training for the provider.

Provide Wrap Around Technical Assistance

Child care directors are busy people, often struggling to retain staff, meet payroll, and stay on top of the many details that go into running a quality program. Acknowledge this by offering to have brief, regularly scheduled meetings with them to monitor the progress of individual children. Use these meetings to discuss ways early intervention services can build the capacity of classroom staff to increase the successful participation of all children. Technical assistance delivered in this manner is aligned with the director's primary goal of providing quality care for all children.

> *I notice that when I go into the centers [now] ... the staff are asking many more questions about serving the kids .... they seem to be using us as resources and supports in ways that they weren't doing before. (Early Interventionist, Temple, TX, 1998)*

Share Your Rolodex

Support for inclusive child care is more forthcoming when child care directors have resources they know they can tap into when a child with disabilities enrolls. The more familiar they are with local medical and community resources, the easier it will be for them to schedule staff training and relieve staff concerns around the care of specific children. Let them know they can count on you. Invite child care directors to training sessions addressing the needs of high-risk children and their families. Nominate them for advisory committees of agencies committed to the care of people with disabilities. Provide them with opportunities to visit the neonatal unit of your local hospital and learn first hand what that environment is like. The more child care directors become part of the early intervention network, the greater the chances of providing seamless services to children with disabilities and their families.

> *When child care directors become more aware of the EI resources available to them, they are much more willing to accept a child with a disability into their program because they know they will have support .... I now have many more calls from child care directors asking questions or looking for resources for a specific child. (Early Interventionist, Parkersburg, WV, 1998)*

Conclusions

Although inclusion of young children with disabilities in neighborhood child care centers has been an ongoing topic in the field, the practice of inclusion lags behind the rhetoric. Child care directors are an untapped resource in changing this situation. We have discussed several ways child care directors can help, as well as strategies to help support their efforts. These include integrating training on the care of children with disabilities into efforts to promote quality care for all children, modifying center policies and procedures, and actively recruiting children with disabilities and their families. Early intervention can support the director's efforts through ongoing wrap around technical assistance, sharing the resources of the early intervention network, and the formation of strong, mutually beneficial relationships.

> *The directors really do need an EI person to talk to and ask questions and use as a support ... and directors can teach EI folks about the realities of child care ... and what kinds of activities are not effective in child care settings. We can learn from each other. (Child Care Director, Morgantown, WV, 1998)*

Note

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Day care for special children

Training helps mainstream centers care for kids with disabilities

By FRANK DAVIES
Herald Staff Writer

Brendon McFarlane, a 1-year-old bundle of energy, rolls across the mats, living up to the name of Royal Caribbean Cruise Lines' on-site day-care center: Little Cruisers. He and several other infants happily bounce off each other like pinballs.

Brendon has a rare type of chronic kidney failure called "prune belly" and requires special medication and therapy. His condition has improved — from twice-a-day dialysis to four times a week — and his mother is hoping a transplant can be arranged soon.

At South Miami Lutheran Pre-School, Christopher Lancaster races around the playground like the other 4-year-olds. He has had epileptic seizures in the past year, and one occurred during naptime. The day-care staff was ready, calling fire-rescue while sliding the other kids, most still asleep on their mats, to the side of the room.

Until recently, Brendon and Christopher would not be in most day-care centers. Their disabilities can require special attention, and many child-care directors and staffers would shy away from taking kids even with a mild epileptic condition like Christopher's.

"We had a few kids with disabilities, but we weren't comfortable with it because we'd had no training," said Yolanda Borrotto, the director of Lutheran Pre-School, which takes care of 117 children.

That has changed dramatically in Dade this year. Borrotto and three of her teachers were among 71 day-care staffers from 18 centers throughout Dade who received special training in caring for kids with disabilities from the University of Miami's Mailman Center for Child Development.

The Mailman Center, in the Jackson Memorial Hospital complex, was one of three institutions in the nation to receive a federal grant for the program, so the day-care centers don't have to pay for the training. More eight-month training sessions have begun — meeting one day a month — including two in Spanish. More are planned, possibly in Little Haiti and Broward.

At a recent final session with about 25 staffers, Sheena Benjamin-Wise of the Mailman

PLEASE SEE **DAY CARE, 3F**

MARICE COHN BAND / Herald Staff

SPECIAL CARE: Diris Torres, a teacher at Little Cruisers, plays with Brendon McFarlane, who has a rare type of chronic kidney failure.

Mainstream day care for kids with disabilities

MARICE COHN BAND / Herald Staff

TRAINING SESSION: Sheena Benjamin-Wise instructs day-care teachers on how to handle kids with disabilities.

DAY CARE, *FROM* **1F**

Center answered questions on autism and attention-deficit disorder, how to deal with anxious parents and where to get help.

"Remember, you are professionals, and you have lots of resources you can call on," she assured them. "Try to understand the stress parents are under, and in some cases you may be the first to notice behavior the parents need to know about."

For the parents, "preschool inclusion" is a tremendous relief and an alternative to giving up working, costly in-home care, or "warehousing" in a place just for the disabled.

"I was very concerned they might ask Chris to leave after he was diagnosed with epilepsy. . . and he just loves it there," said his mother, Jane Lancaster. Chris' first seizure occurred at day-care — just about the time staffers started the UM program.

"They've gone over and beyond what you would expect," Lancaster said of the Lutheran staff. "In fact, they've helped me through this. It was very upsetting to see Chris experience this."

Wears supports and braces

Millie Williams' 4-year-old son, John, has spina bifida, an incomplete closure of the spinal column. He wears ankle supports and braces inside his shoes.

He also has bowel and bladder problems, and at a another day-care "they didn't even change his diaper sometimes. . . it was very upsetting, just like warehousing," Millie Williams said.

Fortunately, Kathy Moll at Lutheran had just begun the UM program, "and they said they'd be glad to take him."

"He's like the other kids in so many ways — he's physical, he has a temper," Moll says.

Barbara McFarlane, Brendon's mother, went through a traumatic year dealing with her new baby's condition. "It was especially hard on my 4-year-old and 10-year-old, because Brendon needed so much attention," she said.

A big plus

Having day-care for Brendon

ters in the Port of Miami is a big plus for McFarlane, who works as a group scheduler for the cruise line. The day-care staff learned about medication, different diapers, a special highchair and ways to strengthen the baby's muscles.

"It was tense at first, but now we know what to expect," said Gladys Montes, the director of the center, which has also cared for an autistic child. "Like the parents, we go through an evolution — denial, acceptance, seeking information."

About once a month, day-care directors, staffers and parents meet with Benjamin-Wise and Susan Gold, who oversees the program at the Mailman Center, to trade ideas and encourage each other.

They have encountered occasional resistance from the parents of "normal" kids at their centers, but during the year they noticed that perceptions changed.

"Sometimes the other parents think the disabled kids are going to require all the staff's attention," said Ginny Pared, director of Paradise Christian School in Hialeah.

Pick up behavior

"Some parents worry that their children will pick up different behavior" from kids who are autistic, or have attention-deficit disorder, said Lisa Heiblum, a social worker at Bet Shira Early Childhood Center in Kendall.

But Montes, at Royal Caribbean, noticed that "most of the parents here have become very supportive of the parents of kids with disabilities."

"We've seen a change in attitude from everyone involved, but remember, so far we've reached only a small percentage of centers," said Gold, who believes the

WHERE TO TURN

■ **DAY-CARE CENTERS:** If you're interested in the training program for child-care professionals, contact Susan Gold or Sheena Benjamin-Wise at UM's Mailman Center for Child Development: (305) 243-6624.

FOR PARENTS: If you think your child — through the age of 2 — has a condition or disability that needs to be diagnosed, call the Early Intervention Program at (305) 243-5600; for children older than 2, call the Mailman Center at (305) 243-6010 or Child Find at (305) 274-3501 in Dade or (954) 767-8522 in Broward.

State legislation passed earlier this year encourages child-care providers to take in kids with disabilities, and eventually will mandate some training.

And there's another tangible benefit to this program: The other kids get to know children with disabilities.

"When we were growing up, the 'special-ed' kids were always in a special class down the hall or in a separate school," said Benjamin-Wise.

Now, at centers like Lutheran, epilepsy and spina bifida may slow down their friends, but it's something 3- and 4-year-olds deal with in a straightforward way.

Last year, for example, the kids at Lutheran took turns pushing the wheelchair of a child who had cancer.

"It's a very accepting age," said Borrotto at Lutheran. "And in their own way, they're learning

A Dilemma for Preschool Teachers: When to Refer

By
Susan Gold
and
Carole Abbott

Research points to the fact that the earlier a problem is detected, the easier it is to either eliminate or remediate.

Sooner or later it happens to every preschool teacher — a child that just doesn't seem to be like the others. Maybe Albert can't seem to sit still for story time; he is always into something. Or maybe Susie doesn't talk much; she seems so quiet and shy. And then there's Ted who just doesn't seem able to grasp anything no matter how much extra time you spend with him.

You as a teacher have a problem. You have the best interest of the child in mind; yet what is in his or her best interest? You're a professional, not a trained psychologist. Maybe the child will simply outgrow the problem. Should you alarm the parents needlessly? What if the problem is not with the child, but in fact, with something that you are, or are not, doing in the classroom? Does suggesting that the child is "different" imply a label? If so, the label may follow the child for a long time. What if it's the wrong label?

Research points to the fact that the earlier a problem is detected, the easier it is to either eliminate or remediate (Senior, 1986). If there is a problem which is not addressed, the chances increase that the child will do poorly in school. In addition, poor school performance often leads to social or emotional problems (Lichtenstein & Ireton, 1984; Reid & Hresko, 1981; Senior, 1986). What courses of action should you take and where can you turn for help?

There is little written specifically for preschool teachers concerning this serious problem. However, a recent study of elementary school children who were referred to school psychologists by their teachers listed the reasons most often given for referrals. They included poor peer relationships, frustration, and academic achievement below expectations (Hutton, 1985). An investigation of problems cited as major reasons for referral at a south Flor
diagnostic center, which evaluates ch
dren for eligibility for preschool exce
tional education, revealed the largest s
gle referring problem among youngste
aged three to five to be speech and la
guage delay. Other high incidence refer
problems included overall delay, "hyp
activity," and behavioral difficulties
other words, generalized and pervas
inappropriate cognitive, social, and beha
ioral variables are all highly used crite
for referral of preschool children.

There are many references to the fa
that students can be and often are mis
agnosed and misplaced (Algozzine & Yss
dyke, 1981; Ysseldyke, Algozzine, Shi
& McGue, 1982). Lieberman (1982) poi
to the problems of both over-refer
which he sees as the failure of the regu
classroom teacher to meet the needs
children, and under-referral, which den
needed services to children who wo
benefit from specialized teaching. I
longitudinal study which looked at beh
ior problems, Rubin and Balow (19
found that 57 percent of all subjects h
been classified differently by different tea
ers! That is, children who were rated
their teachers as demonstrating scho
related difficulties one year were rated
functioning normally the next yea
another teacher and vice versa.

Knowing all of this, what can you
Three steps that you may consider a
systematic observation, use of screen
tests, and parent conferences.

Systematic Observation

Preschool teachers often forget th
they are actually astute observers of c
dren (Shinn, Tindal, & Spira, 19867). A
preschool teacher, you have a classro

One of the most basic and yet useful tools at your disposal is that of observation of children in typical work and play activities.

full of children which provides a background of information as well as a basis for ongoing comparison. Further, you see the child in question many hours per week in a variety of situations. One of the most basic and yet useful tools at your disposal is that of observation of children in typical work and play activities. To help with this, checklists, rating scales, and other forms for keeping anecdotal records have been devised.

Observations should be designed to assess various aspects of the child's functioning. Leigh & Riley (1982) suggest the following:

a. What learning strategies does the child endeavor to use with various tasks?

b. What specific content (e.g., letters or numbers) does the child know?

c. Which basic concepts has the child acquired?

d. How does the child interact with other children in small groups?

e. To what type of reinforcement does the child respond?

Additional areas appropriate for observation include the child's level of social awareness. Does the child demonstrate behavior in the school social environment that is similar to that of his or her classmates? Does he talk to and interact with both peers and adults? Does he have friends? Similarly, in emotionally provoking situations (e.g., stressful, exciting, sad), does the child react in an age appropriate manner? Also, what are the physical, both fine and gross motor, characteristics of the child? Is the child overly clumsy or lacking in coordination? Does the child always seem to spill or bump into things?

Two crucial steps in using systematic observation are the actual observation and the record keeping. **Observation** should be a planned effort and considered an integral part of your curriculum. **Record-keeping** should be done in a systematic manner even though it is a time-consuming task. Choose a method that works for you. Some types of observations include time sampling, anecdotal records, and specimen description (Cryan, 1986; Rowen, 1973).

An effective way of beginning to observe an individual child is with the use of ten-minute time samples (Rowen, 1973). When using this method of observation, the teacher should select a period of time when full attention can be devoted to the task. Every crucial aspect of the child's behavior during the time period, such as facial expression, use of hands, and whole body movement, should be recorded. If the child speaks or makes sounds, the exact verbalization should also be recorded. The time should be noted in the margin at one- or two-minute intervals.

An effort should be made to record only overt behavior in one column and comments and interpretations in a parallel column or at the end of the sample. Specific behaviors can then be counted. Before beginning the observation, define "on task" and "off task" behavior. After the observation, tally all behaviors. For example, how many times is Albert off task during a 10-minute story time or seat work time? That is, how many minutes is he not focusing his attention on the specific assigned task. Other behaviors that may be considered off task include talking out, getting up from his chair, gazing away, or "playing" with the materials. You may do this time sampling, for example, once every two hours for three days or whatever seems practical and convenient for you.

Anecdotal records differ from time samples in that not every detail of an incident is reported minute by minute. Anecdotal records involve writing statements of specific, critical incidents and can be done after the event has occurred. However, for the sake of accuracy, the closer to the event the better. It may also be an on-the-spot record which the teacher jots down as it happens. An example would be noting specific aspects of Susie's language behavior. Does she seem to comprehend and follow specific verbal directions? Does she rely upon gestures or cues from other children to do so? How and when does she verbally respond? When does she use spontaneous speech? Is her speech intelligible? Does she speak in one word utterances or sentences several words in length? Is her verbal interaction different with adults than with children? Reading back over several days' worth of anecdotal records may help to clarify issues and provide helpful information.

Specimen description involves identifying a situation and recording all events occurring within that situation. According to Cryan (1986), video or audio recordings are often used, and the teacher can later code the data, noting antecedents and consequences of target behavior. However, sophisticated equipment is not necessary. Simply describing what happens when you present any type of new material to Ted may provide clues as to his learning process. What methods do you use? Do they employ verbal, visual and tactile senses? Is Ted better able to attend and concentrate when one particular teaching technique is used as compared to others? When does he attempt the tasks? Are there specific areas in which he demonstrates more difficulty, such as not being able to remember, not being able to work with a pencil, or not working well with material presented auditorily as opposed to visually?

Observation methods are appealing to teachers because of their flexibility, simplicity, adaptability, and utility. An individual folder can be kept for each child in the class. In addition to samples of art work and/or writing, anecdotal records and time samples can be dropped into the folder. Review of materials in the folder from time to time gives the teacher an awareness of changes in behavior, growth patterns, and persistent problem areas. On the other hand, these observation methods are limited by the observational skill of the observer, observer bias, and the ease or difficulty of recording.

Preschool Screening Instruments

Many preschool screening measures are available which can provide a more objective indication of a child's functioning. Screening tests are not meant to be specifically diagnostic in nature. Generally, they consist of a few tasks that are classified according to developmental areas such as social skills, language, gross and fine motor and cognition. A low cumulative score in one or more areas might suggest the advisability of an in-depth evaluation.

It is important to be aware that there are numerous problems associated with existing preschool screening instruments (Meisels, 1987; Mercer, 1979; Reid & Hresko, 1981). For example, these tests are designed for use by persons not trained as examiners. Procedures and scoring criteria are often loosely defined in tests manuals. This allows for the possibility of dissimilar results and interpretations being reported by different testers. Also, seldom do these tests rest on extensively established realiability which confirms that the screening measure will give consistent results time after time. Another difficulty surrounds the issue of whether or not these tests are valid, or actually measure what they say they measure. For example, does a low score in fine motor development really mean delayed development or was it the result of a misunderstanding of task demands, poor comprehension of verbal instructions, or a visual-motor integration problem?

. . . early detection should lead to appropriate intervention that will, in turn, result in rewarding benefits for both the child and his or her family.

Finally, one of the most serious problems involves the test phenomenon which results in children whose cultural and/or economic backgrounds differ from the "average" (white, middle class) child achieving test scores that are, in general, lower than "average" (Cole, 1981; Jensen, 1973; Jensen, 1980). There is no agreed upon definitive answer for why this tends to occur. Experience with specific materials, language similar to or different from the mainstream language, familiarity with test-taking behavior and general, overall exposure to a wide variety of experiences are only some of the reasons cited for this predictable difference in scores. This confuses the interpretation of test results and poses the question of whether separate cut-off scores should be used for diverse groups of children.

Despite these problems, screening instruments can often add additional information which may lend support to your decision as to whether or not to refer. With the recent federal legislation which mandates exceptional student services to preschool children (P.L. 99-457), additional preschool screening tests are being developed which intend to do away with some of the existing problems. Meanwhile, Melcher, McCoy, Lange & Kammen (1980), reviewed approximately 60 instruments that are currently used in early childhood programs. Those that have proved useful to the authors of this article include Developmental Indicators for the Assessment of Learning — Revised, DIAL-R, (Mardell-Czudnowski & Goldenberg, 1983), The Denver Developmental Screening Test (Frankenburg & Dodds, 1970), The Dallas Preschool Screening Test (Percival, 1972), and the Battelle Developmental Inventory and Screening Test, (Newborg, Stock and Wnek, 1984).

Parent Conferences

A conference with parents is yet another way of gathering valuable information. Conferences may be formal or informal. The key is careful listening on the part of the teacher to determine concerns the parents might have. Much has been written about good communication skills and how they apply to parent-teacher conferences (Bjorklund & Burger, 1987). It is always important to remember that parents love their children and want to do their best in raising them. With this thought in mind, you can begin to establish rapport and to convey a friendly acceptance of the parents and their feelings. Inquiries about the child's activities at home, his or her playmates, and any recent changes, either in the child's behavior or in the home environment, are in order. You may want to ask what the child reports about school. Questions to the parents about the pregnancy, birth, and postnatal history of the child may also yield important information. These questions are not usually included in the entry records available at most preschools. Assure the parents that your interest in these relatively personal matters is only to enable you to examine potentially important factors that may influence their child's current school performance.

If parents seem worried about their child, a parent conference is a good opportunity to share some of the observations you have made and to voice your own concerns. However, if they have not expressed any particular worries, the conference may be the first time they are confronted with the possibility that their child is not performing up to expectation. Such a situation must be handled with the utmost tact and understanding. You may find resistance even when parents suspect a problem. Talking helps parents identify their concerns and verifies the existence of a problem. Reiterate that you are observing the child at this time. Suggest that the parents also observe their child in comparison to behaviors of others his or her age. Outline your plans for gathering more information. This may include talking about the child with other professionals such as a pediatrician, psychologist, or neurologist.

Hopefully, you also have a support system that you may consult; either another teacher, the preschool director or principal, or perhaps a school nurse or counselor. Downing (1985) reports that teachers who feel that efforts are being made to assist them with children who exhibit atypical behaviors are more likely to continue creative attempts to reach those children.

Ysseldyke, Pianta, Christesnson, Wang & Algozzine (1983), asked teachers to list alternatives that they had tried in the classroom prior to referral. Some or all of them may be helpful to you. They are divided into the following six categories:

a. Methods — changes in your teaching including forming small groups, varying curriculum, repeating directions, or prompting appropriate behavior.

b. Behavioral — employment of positive or negative reinforcement.

c. Structural Change — utilization of peer tutors or aides, schedule or seat changes.

d. Specialized help — provision for services such as speech therapy or counseling.

e. Materials — provision for items su as tapes or other audio-visual materi and a wide variety of games, puzzles, a other objects which children can exam and manipulate.

f. Informational — referral to child stu team, diagnostic evaluation, conferer with parents or other specialists.

What Next?

If you do suggest referring a child further formal evaluation, his or her p ents may need time to process this in mation. They should be helped to unc stand why such a referral is being sugg- ed. The goals to be accomplished shc be clarified. If this process is caref handled, the referral can be seen as a for appropriate help rather than a thr Too often at this stage, parents becc unduly alarmed or guilt-ridden.

When it is agreed that there is a need further evaluation, where can you turn help? A search of your community shc be made to locate all possible resour The public school can put you in to with the local CHILD FIND specialist. find this number in the white pages of phone directory. Supported by state federal funds, this person arranges for evaluation of children who are not rently in public schools and who are pected of requiring exceptional stuc education services. This is part of the p lic school service so there will be charges made to the parents. Local leges and universities also often offer c nostic services or perhaps can rec mend private psychologists, occupati or physical therapists, or speech and guage specialists. Inquire about this w consulting these resources. Possib DIRECTIONS SERVICES has been es lished in your geographic area. This national movement to establish a com er network listing resources availabl parents of children with definite or pected handicapping conditions.

After locating all possible resourc your community, the question becor "Who can best respond to which par lar need?" The degree to which you knowledgeable about local resources help parents avoid the "runaround drome" — fruitlessly going from office to another. Downing (1985) lists following guidelines concerning refer

a. Know the professional to whom refer the child.

b. Provide the parents with more one resource.

An in-depth evaluation may indicate that the child is, in fact, developing within normal limits.

c. Refer to a specific person when possible.

d. If uncertain as to the appropriateness of your referral to a specific agency, contact that agency before referring the parent.

An in-depth evaluation may indicate that the child is, in fact, developing within normal limits. This will greatly relieve the concerns of both parents and teachers. On the other hand, if a problem is found, its early detection should lead to appropriate intervention that will, in turn, result in rewarding benefits for both the child and his or her family.

Once the referral is made, your role in the process is not over. Referral-making should be interactive in that the professional making the referral and the professional receiving it communicate on a continuing basis for the benefit of the child. If the child remains in your classroom, try to obtain a copy of the report and be prepared to act on any recommendations.

For example, Albert, Susie, and Ted were all referred to Child Find where each received a complete psychoeducational evaulation. Albert was diagnosed as manifesting an Attention Deficit Disorder but his preschool skill acquisition was, nonetheless, satisfactory. He was returned to his regular classroom with suggestions for behavior management to assist in his attending behavior. He will be carefully monitored throughout his school years for being at risk for developing learning disabilities.

Susie's evaluation indicated that she exhibited delayed language skills. She also returned to her regular preschool program but attends speech therapy twice a week at her local public school. Susie's preschool teacher remains in close contact with her speech therapist so that they coordinate their efforts to increase Susie's language skills.

Ted was found to display delays in all aspects of his development. He was diagnosed as mildly mentally handicapped and is enjoying success in a public school exceptional student preschool program. He is receiving individualized attention and learning at his own pace.

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Conferring With Parents When You're Concerned That Their Child Needs Special Services

Carole F. Abbott and Susan Gold

Sometimes a special type of parent-teacher conference is necessary: one in which parents may hear for the first time that the teacher is concerned about some aspect of their child's development. Much has been written for teachers about having conferences with parents (Manning, 1985; Price & March, 1985; Bjorklund & Burger, 1987). These articles offer important suggestions concerning planning, conducting, terminating, and following up the conference. Other articles (Barron & Colvin, 1984; Ellenburg & Lanier, 1984; Healy, Keesee, & Smith, 1985; Lavine, 1985) stress communication skills and encourage jargon-free conferences as well as active listening on the part of the professional. What has not been widely written about, however, is help for the teacher who is about to discuss a subject that parents may be unprepared to hear or accept. How do you, as the professional, confer with parents about your perception that their preschooler does not appear to be progressing normally in one or more areas of development? How do you suggest to them that more information may be needed and work with them to arrange for a referral? If you have not been through this process the suggestions that follow may be of help to you.

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A sequence of events should have taken place before you, the teacher, decided to arrange for this particular conference (Gold & Abbott, 1989). Briefly, preschool teachers with a solid early childhood education background are urged to trust themselves when they feel a child may have a problem. Credentialed early childhood teachers are trained observers of children (Rowen, 1973) and they have many other children in their class approximately the same age with whom to compare the

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child in question. Teachers, along with parents, are the most obvious persons to be involved in recognizing a possible delay in development.

First, teachers ought to look at their own daily programs to determine whether they can make modifications that will alleviate any individual problems. Teachers can also seek advice and support from other professionals, certainly including the director or principal. A file should be kept containing samples of the child's work and behavioral observations. Informal contacts as well as conferences with parents can be held to determine whether the parents notice specific behaviors at home and whether they have special concerns about the child. Screening tests administered by classroom teachers are also a means of adding information or reinforcing ideas about a child (Gold & Abbott, 1989; Meisels & Province, 1989).

As the teacher, what do you do now? If your concerns about a child persist and you want a more extensive assessment, a conference is merited.

Consulting with parents

Arranging for a conference in which you feel like the bearer of distressful news requires extra sensitivity and care. You will want to create an atmosphere of trust and understanding to facilitate relaxed, open communication. Speaking to a parent in person or by telephone are the most personal ways to arrange a meeting time and place. When in-person or telephone contact is not possible, a note sent home with the child or a letter mailed directly to the home will also work.

Identify the purpose of the meeting. For example, you might say something like, "Mrs. Jasper, I have been observing Susan very carefully over the past few weeks and have been keeping careful notes on her reaction to the changes we have made in her program. I would like to know if you have noticed any changes at home. I think it is important for us to get together and decide how best to continue. Could you please meet with me?" If the parent presses you for more information, simply say that you still have some concerns and that you can explain them more fully when you can speak in person. Try to set up a meeting in the next few days to reduce anxiety.

In two-parent families, if at all possible, it is important that both parents come. Leaving one parent to tell the other what was discussed can lead to misunderstanding and confusion. Working together produces better long-term results.

Planning for the meeting

This conference should be especially well planned. Price and Marsh (1985) suggest certain guidelines. They advise choosing a site for the conference that provides privacy and comfort in terms of temperature and lighting. An informal seating arrangement is more conducive to conversation than being seated on opposite sides of a desk. Allow ample *time* because checking watches may be distracting to everyone.

If a preschool teacher suspects that a child in her group has a special problem, it is important that she consult with the staff and the child's parents to gather more data and to share her concerns.

You, too, may be somewhat anxious about this conference. Because confronting serious problems is never easy, you may be tempted to state your observations vaguely, or to suddenly forget the details which were crucial in your decision to ask for the conference. Preparing appropriate materials ahead of time and organizing them in a meaningful manner will help avoid such pitfalls. For example:

- Collect *samples* of the child's recent work.
- Have *anecdotal records* available that carefully document episodes and lend support to the position that you are presenting to the parents. These should be dated and should represent samples of behavior over a period of several weeks.
- List the special *modifications* that you have made in your program in an attempt to help the child learn more effectively.
- List names of other *professionals* who may have assisted you in coming to your decision with a summary statement of their thoughts.
- Have the names, addresses, and phone numbers of *agencies* in your area to whom you can refer the parents. Be specific regarding referral sources. Have available information for Child Find and/or the local public school authorities, as well as for any other public agencies (e.g., local mental health centers) that provide diagnostic and/or counseling services. In case the parents may wish to consider a private psychologist, be ready to supply the name of two or three who are familiar to you.

The meeting itself

The parents will understandably be anxious about the meeting, so it is important for you to try to make them

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comfortable by being ready and welcoming them when they arrive. Try to remember that this is a cooperative effort around the child's needs.

Getting parents' perceptions

It is a good idea to start the meeting by asking the parents how the child has been doing at home and if there have been any changes in behavior. For instance, "Mr. Potter, when we last talked, we discussed three specific activities that you could do at home with Amy. Have you been able to try any of these? Tell me how things went." Or, "Ms. Clay, you have been watching Tommy play with his cousins who are about his age. How do you think Tommy's overall behavior compares to theirs?"

Talk with the parents about their perceptions. Ask them to give specific examples. Parents usually know their children very well and often such a discussion will provide the opening you need. For example, "Yes, Mr. Potter, we also found that helping Amy to begin a task was somewhat effective, but she still has real trouble being able to finish the task without considerable help," or "Ms. Clay, we too, find that Tommy behaves somewhat differently from the other children in the class. He behaves like a younger child. Let me show you some of his work."

Try to keep your discussion basic, simple, and to the point. Even the most sophisticated and educated of parents may have difficulty internalizing what you are saying. Try to get the parents to paraphrase back to you what has been said so you know they comprehend—or at least are hearing—what you are telling them. "Ms. Clay, does Tommy talk as well as his brother did when he was Tommy's age?"

It may not take long to arrive at this point in the conference, especially if you were careful to state your reason for calling the conference in the first place. It will be appropriate now to tell the parents that you feel their child should be referred for a developmental assessment. "Ms. Clay, we seem to agree that Tommy is showing delays in his ability to talk," or "Ms. Clay, we don't seem to agree that Tommy is showing delays, but I think we ought to get the help of some experts. I feel it is important that Tommy be seen by a person who can assess his performance and tell us whether there is a real problem and if so, how we can better help Tommy."

Dealing with parents' reactions

It is probably not necessary at this time to talk about "special" or "exceptional education." Not only may that be distressing to the parents, but it is also premature. Such discussions are best left for the psychologist or another member of an inter-disciplinary assessment team and should take place only after the actual assessment has taken place. Under *no* circumstances should you label the child or attempt to diagnose a problem. This is not the function of a teacher.

Recognize that during the conference, parents may panic or show signs of anxiety, grief, or depression. These are all common and understandable reactions for parents with children who demonstrate developmental delays (Strauss & Munton, 1985). Try to be an active listener and allow them to express their feelings. Be prepared to listen to expressions of anger and sadness. Parents may also blame each other. Try to focus them on the problem. Be prepared, too, for tears. Have a box of tissues easily within reach. You may need to interpret feelings that have not been verbalized but which parents display through body movements, facial expressions, or posture. Respect the parents and their feelings.

Emphasize that you do not know what the results of the assessment will be. Rather, using your expertise, you have indicated that you *think* there may be a problem. Be confident that it is in the best interest of the child and the parents to determine whether a true problem exists as early as possible in order to address it immediately. If, on the other hand, the assessment indicates there is no developmental delay, both you and the parents will be greatly relieved. In either event, the assessment should be viewed as something positive rather than negative.

The referral procedure

If the parents decide to follow through with an assessment, they need to choose where to have it done. You may provide some information.

The passage of P. L. 99–457 requires public school districts to provide free evaluation for children from the ages of three to five who may have special educational needs. These assessments *may* also be provided for children from birth through age two although it is not required of the states. Some school districts are already providing these services along with preschool classes for children who are found to have special educational needs. If the parents decide to take advantage of this public service, call your local Child Find Specialist, who can help you locate information on what is available in your state. The number should be listed in the local phone directory, under Child Find. If not, call the local public school area or district office and speak with the Director of Special Education. Either the parent or you, as the child's teacher, may call in the referral, although parental permission ultimately will be required to conduct the assessment.

The Child Find Specialist will want permission to review all of the child's medical, school, or other special services or assessment records. The parent will be asked to sign a release enabling the specialist to obtain these records directly from the institutions involved. The specialist may also ask the parent and you to complete forms giving more information about the child. It will be important to notify the specialist that a developmental or psychological screening test was already conducted, if this is the case, and to supply the results. If one has not been conducted, the specialist will likely do that prior to scheduling a complete assessment. After all the records are received, the specialist will contact the family about scheduling a date for the assessment.

Assessment

The child's family may decide to go to a different agency, to a private school that provides this service to potential students, or to a private psychologist. Again, a phone call inquiring about the referral process will be the first step.

No matter who does the assessment, it is likely that a qualified professional will ask for the teacher's input. In fact, it is appropriate for you to suggest to the parents that they request that you be consulted, since you have valuable information. It is important that the evaluation data consist of more than test scores based on a few hours in a testing room.

Also, suggest that the parents inquire about the length of time required for assessment. A thorough assessment may consist of three or more hours and may be conducted over the course of one or more days. A snack for the child during breaks may be recommended.

Finally, tell the family that they

Under no circumstances should the teacher give a "guess diagnosis" to parents. The purpose and focus of this conference is to state the need for a specialist's assessment, so that both parents and teacher can plan most suitably for the child.

should ask how soon the results can be obtained. They should also be told to inquire what services or recommendations are likely to be forthcoming from the person or agency who conducted the assessment.

Support the family

You may be the first professional, other than a physician, with whom the parents have had contact about the development of their child. Seeing the child every day, you are in a position to be relatively impartial, unemotional, and yet supportive. There may be a delay until the assessment is completed and the results known. During this time the child will likely still be a part of your classroom. Just knowing that help is on the way may give you some psychological support in working with the child. You may find things easier in the classroom. This is a good time to reassure the parents that they have done the right thing.

After assessment

Several outcomes are possible as a result of the assessment. The child may be seen as "not delayed" and remain in your classroom. Reactions of parents, in this case, may vary from relief to possible anger at you for what you have "put them through." Calmly remind them that you used your best judgment and are as glad as they that there are no significant problems. Tell the parents that you will want to get information from the diagnosticians who evaluated the child in order to gain insight regarding how to best work with the child in your classroom.

Another possibility is that the child may be seen as having a slight problem that can be remediated while attending your program. Examples of such remediation might include speech therapy or play therapy. Every attempt should be made to work with other professionals who provide these services to the child so that all efforts will be coordinated.

The setting for a parent/teacher conference should always be as welcoming and informal as possible. The touchier the topic to be talked about, the more important this is.

The third possibility is the recommendation that the child will best benefit from another placement and will be transferred from your classroom. This should not be interpreted as a failure on your part or that of the parents. It should be viewed as a move that is in the best interest of the child. With the parents, find out as much as you can about the recommended placement and support the family with this transition. Be mindful, too, of the need of the child and classmates to say goodbye to one another.

Discussing distressing news is never easy. If the idea of referral for an assessment is considered in a negative way, it will not be easy for you to suggest. However, if you believe that an assessment is another tool for gathering information in order to better work with a child, you will be able to remain positive in your approach. Unfortunately, we sometimes do not refer young children because of the fear of "labeling" or "mislabeling" or because we hope the child will "outgrow" the problem. In too many cases, we do the child and the family no good by not recognizing and acting on a problem. Be confident in your ability to know the children you teach, and act on their behalf.

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ncluding Young Children with Special Needs in Early Childhood Programs: Where is Florida Headed?

For most families throughout the nation, accessing and affording quality child care is a significant issue and one that dramatically influences the economics and quality of life for all family members. Much has been written about the three-fold problems of child care: availability, affordability, and quality (Florida Children's Forum, 1999; Neugebauer, 1998; Scarr and Eisenberg, 1993). For families of a child with disabilities these challenges can be particularly significant, since the needs of their child often place additional barriers (perceived and real) to accessing necessary and appropriate services (Mackey-Andrews, September, 1998).

What is inclusive child care?

Inclusive child care is defined as the child care center or family child care home the child would usually attend if that child did not have a disability. The term inclusion is often referred to as mainstreaming or integration, but each of these words may have a different connotation, depending on the speaker.

For children with disabilities, inclusive child care means utilizing the same child care services and settings as children without disabilities, participating in the same activities, being part of the group, and developing friends. Most importantly, it means having the option to use the same services in the community that all other children use instead of being isolated in a world where there are only children with disabilities.

What does the law say?

The law which has probably provided the greatest impetus for including children with disabilities in child care centers and family child care homes is the Americans with Disabilities Act (ADA). This federal civil rights law was passed in 1990. The Act states that people with disabilities are entitled to equal rights in employment, services, and public accommodations such as preschools, child care centers, and family child care homes (Rab and Wood, 1995). Many accommodations need not be difficult or expensive. For more information contact the Child Care Law Center, 973 Market Street, Suite 550, San Francisco, CA, 94103; phone: 415-495-5498; fax: 415-495-6734; e-mail: info@childcarelaw.com; and web site: http://childcarelaw.com.

The forerunner for inclusion in child care has been special education and early intervention legislation. The major emphasis of each law is to provide services to the child in the "least restrictive" or "natural" environment. Since 1975, federal law (P.L. 94-142) has required that children with disabilities be provided a free and appropriate public education and that services specified in the child's Individualized Education Plan (IEP) be provided in the "least restrictive environment." While states had the option of serving children under the age of five through P.L. 94-142, few elected to do so.

Through the passage of P.L. 99-457 in 1986, services to children under age five were encouraged nationally through major amendments to the federal statute and regulations. All states, under this new legislation called IDEA or the Individuals with Disabilities Education Act, were required to provide services at no cost to eligible children, ages 3 to 5. A voluntary program (originally Part H of the 1986 legislation) known currently as Part C of IDEA, encouraged states through incentive funds to establish coordinated systems of services for infants and toddlers and their families. Principles under this voluntary legislation included provisions to serve children at risk as well as those with diagnosed disabilities and medical conditions likely to cause or contribute to developmental delay. Individual state eligibility criteria vary widely. Part C has also required that services to eligible infants and toddlers and their families be provided in natural environments, and that the family serves as the center for the planning, delivery and evaluation of early intervention services.

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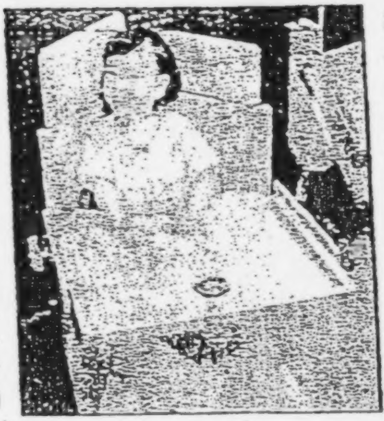

ɜ 1997 amendments to IDEA through)5-17 served to reinforce the existing ement for natural environments by ; the requirement that documentation in mily Support Plan must appear when rvice is not being provided in the natural nment of the child and family. Natural nment, as used in this context, is not ɪe location of services – but the approach ıanner in which services are provided, ırting a greater emphasis upon family-ed services designed to enhance their :ity to respond to the developmental ; of their child.

ırt C of IDEA states that "to the maximum t appropriate, [early intervention services] are ded in natural environments, including the ː, and community settings in which children ut disabilities participate; and the provision of intervention services for any infant or toddler rs in a setting other than a natural environment when early intervention cannot be achieved factorily for the infant or toddler in a natural onment." Determining the natural environment ach child involves considering the unique needs, ities and resources of the child and family.

ɅS such, child care centers including family child homes, are often the most natural environment ıe infant or toddler. Families are encouraged to tify the provider within their community that they ıld be most likely to use. It is then the ɔonsibility of the Part C system within each state ssist that setting to respond to the special needs ıe child and participate in the delivery of services, ɜther with the family, using the natural routines, vities and schedules of the family and child.

there a lack of inclusive child re in Florida?

In April, 1999, the Florida Children's Forum)lished a report entitled "Charting the Progress Child Care in Florida – County by County." On ɜrage, for every slot in a child care center or family ld care home, there are two children under age ɜ. While these numbers vary somewhat county county, no county was without a waiting list for ɔically developing children.

There is no data available in Florida to determine ɜ number of children with disabilities or special health care needs that are being served in neighborhood child care centers or family child care homes. In 1997, an attempt was made by the Florida Children's Forum to add a question to their market rate survey to determine the number of children with disabilities being served. There were 16,000 surveys distributed with 11,848 respondents, a 69% return. Twenty-six per cent, or 4,505 of the programs, reported that they served or had the capacity to serve at least one child with a disability in their program. Out of the 275,000 children in child care represented in this sample, 8,896 were reported to have a disability. This number is deceiving, however, because of the confusion of the respondents as to who exactly was the child with the disability or special need. Many center directors either over or under-reported these numbers. A new survey is being pilot-tested which we hope will yield more accurate information.

In spite of the lack of empirical data, the frustration of parents of children with disabilities trying to find quality inclusive child care has been heard (Mackey-Andrews, October, 1998). While a great deal of attention has been given to the lack of quality child care for children who are typically developing (Collins, 1997; Collins, 1996; Dicker & Schall, 1996; Kisler & Ross, 1997), this same attention has not been focused on child care for children with disabilities or developmental delays. In fact, most people in our state do not even realize that there is a lack of inclusive child care for children with disabilities of all ages.

What are the reasons for this lack of inclusive child care?

There are many reasons for this lack of options for inclusion. One is a lack of training and technical assistance around inclusion issues for child care personnel. Many caregivers are concerned that they don't have the skills or specialized equipment that might be needed for a child with special needs (Bruder, 1998; Gold, Liepack, Scott, & Benjamin-se[illegible]8; Peck, Carlson, and Helmstetter, 1992). re[illegible]s are also worried that they won't be able neet the instructional and developmental needs young children with disabilities (Hanline & Daley, 99). They are concerned that having a child with disability will require so much of their time that ey will neglect the other children. And teachers port they don't have enough planning time to ccessfully include children with special needs cruggs & Mastropeiri, 1996).

A second reason for the lack of inclusion lies in e concerns voiced by many parents. Parents of hildren with disabilities wonder if their child will eceive all the attention needed. (Guralnick,1994; reen and Stoneman, 1989). They worry about pecialized services their child needs and whether uch services, including speech, occupational and hysical therapy, will be delivered in a child care enter. Goldberg (1992), in fact, says that parents' difficulties obtaining needed specialty services are more stressful than their children's disabilities.

Parents of children without disabilities also worry that their children will not receive the time and a[illegible]ion they require (Peck et al., 1992). There is a[illegible]ne concern that their children will learn bad habits from those with disabilities. However, research does not bear this out (Hanline & Daley, 1999).

A third reason for the lack of inclusion is the attitude and comfort level of adults regarding people with disabilities (Eiserman, Shisler and Healey, 1995). Positive attitudes toward persons with disabilities are essential to successful inclusion. The severity of a disability can also affect the quality of inclusion. Buysee, Wesley, Keyes & Bailey (1996) report significant differences in teachers' comfort levels as a function of the level of the child's disability.

All of these factors, together with the scarcity of quality child care services in general, combine to force many families of children with disabilities or developmental delay into poverty and unemployment because they are unable to find care for their child during their working hours (Craig & Haggart, 1994).

A series of provider and parent forums conducted in the summer of 1998 regarding [illegible]clusive child care confirmed many of these barriers [illegible]d produced the following disturbing data. In the provider forums, training was cited as the paramount need, followed by on-site consultation for specific children, and funding for additional personnel. In addition, providers did not realize there were children with disabilities in their community needing child care. This latter finding was particularly disturbing because providers reported not "seeing" children with disabilities within the community in general–reinforcing the observation that families with children with special needs are generally isolated from their own peers, community services, and activities.

Of the families participating in the parent forums, 75% of families were unable to work due to the lack of child care for their child with a disability. For the same reason, 21% were working in jobs that were part-time, seasonal or well below their training and ability (Mackey-Andrews, 1998).

While much has been written about the concerns around inclusion, there is also well-defined literature on its benefits. One of the most often cited positive aspects of inclusion for children without disabilities is the social/emotional benefit. These include friendships developed between children with and without disabilities and a sense of awareness and sensitivity to the needs of other children (Gellens, 1996; Peck et al., 1992). Benefits for children with disabilities include all of the above as well as increases in academic and developmental skills and learning age-appropriate behavior from watching their peers (Bennett, Deluca, and Bruns, 1997).

Child care staff at inclusive settings report increased comfort with human differences, increased acceptance of people as individuals, and awareness of access and inclusion issues (Hanline, 1985). Benefits to the early education and child care program may include increased recognition for their efforts such as certificates of participation in training, being listed in brochures, mention in newspaper articles and the satisfaction of knowing that they are serving all children and families equally.

Organizations such as the NAEYC and Division of Early Childhood (DEC) of the Council for Exceptional Children have published position papers on the value of inclusion. A Philosophy Statement written by the Florida Department of Education in 1994 recognizes that, "Inclusion is not a quick fix, but rather a long and considered process of change."

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t is being done in Florida?

orida has already begun to undertake activities ld the capacity of child care providers to care ildren with disabilities and the Department of ren and Families (DCF) has taken the lead in e of these activities. For example, an luction to children with disabilities and inclusion luded in the 30-hour (soon to be 40-hour) ng for child care providers. In addition, an nced special needs rate is available to child centers and family child care homes who pt children with diagnosed disabilities in idized care. DCF continues to work on funding es.

Vork and Gain Economic Self-Sufficiency GES) legislation recently passed in Florida had e important elements regarding child care and lren with disabilities. For example, it is now state y to facilitate serving children with disabilities. the DCF provides technical assistance through Child Care Forum. In addition, child care center ers and operators must take training in serving dren with disabilities within five years of uming their position.

During the summer of 1998, a strategic planning cess was conducted which brought many key yers at the state and local levels together to ermine where Florida was and what we needed lo in order to develop a plan for building inclusion Florida. Over fifty people met for four, 2-day ssions to develop a written document detailing ir vision of inclusion for Florida's children with abilities. Some of the strategies entail more laboration at the local and state level. Some of ese strategies entail better utilization of existing sources and funding; some of them focus on ilding the basic quality of child care for ALL ildren; and some require training and technical sistance for child care providers (Mackey- ndrews, 1998).

As a direct result of this planning process, two gnificant things were immediately accomplished. ne was that Florida submitted and was awarded prestigious Map to Inclusive Child Care grant. We ere chosen as one of ten states to participate in a deral initiative funded by the Administration on hildren, Youth, and Families. This grant will provide s with the opportunity to assemble a team of stakeholders who, with technical support, will determine their own strategic goals and priorities. These goals might be in the area of legislation, staff development, regulatory practices, interagency collaboration, or others. A group of fifteen individuals participated in a National Institute on Inclusive Child Care in Washington, D.C.

The second outcome from this work group was the initiation of three inclusion pilot projects. The Department of Children and Families and The Florida Developmental Disabilities Council have collaborated in funding these pilot projects for inclusion of children with disabilities into child care. The projects are very different in each community. In Clay County, the emphasis is on preparing the community and the providers for inclusion by intensive training and creating community awareness. In Miami-Dade County, the training that is imperative before quality inclusion can take place has already been started (Gold, Liepack, Scott & Benjamin-Wise, 1999). Therefore, the emphasis in that community is on supports needed for specific providers such as, but not limited to, adaptive equipment, supplies, staff assistance, or minor physical modification of construction. Broward County is concentrating on inclusion in before and after-school care.

Implementation of the strategic plan recommendations is anticipated to continue under the guidance of a coordinator hired by the Florida Children's Forum to facilitate buy-in and action by the state agencies and other local and state business and parent leaders.

With the conclusion of the 1999 Legislative Session, Florida began several new initiatives that

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ill greatly enhance the child care industry's ability [illegible]de children with disabilities. First, a new [illegible]vational and developmental assessment rogram was adopted. This initiative will offer a hree-phase process for identifying children with otential disabilities and delays, informing parents, nd referring the children to critical interventions. Second, a regional system of technical assistance for serving children with disabilities was established. This system will offer on-line, telephone, and on-site technical assistance to child care providers on topics such as adapting the environment for serving children with disabilities, and where to obtain additional training and related services. Third, language was approved providing clear authority for the establishment of a special needs rate for children with disabilities. Finally, a new program to provide supervised care for older children, ages 13 through 17 with disabilities, was created.

[illegible]ecial Instruction Consultants – A Well-Kept Secret

The Special Instruction Consultant Service is a service that is provided in typical child care settings by individuals with expertise in the area of special instruction and curriculum development for infants and toddlers with special needs. This service is funded by Children's Medical Services/Early Intervention Program for infants and toddlers who are eligible for Part C and for whom this service has been authorized through the Family Support Plan (FSP) process. Unfortunately, this "well-kept secret" is under-utilized in Florida. Special instruction consultants may provide information to the child care provider in the areas of designing learning environments, activities that promote the child's acquisition of skills, curriculum planning, and achieving the outcomes in the child's FSP. This service is intended to be provided in those situations when the family chooses [illegible] have their child cared for in a typical child care [illegible]etting and the child care agency needs support and information.

What Still Needs to Be Done?

It should be apparent that Florida is committed to increasing the opportunities for inclusive child care. However, we have a long way to go. We need to build awareness across the state of the need for inclusion, the resources available, and the advantages for all families. There must be a strong foundation of quality child care, for all children, and especially for children with disabilities. This includes adequate ratios, developmentally appropriate practices, and training and technical assistance to child care providers so they are comfortable and capable of responding to the particular needs of children with disabilities. There must be greater collaboration at the state and local levels, so that inclusion of children with disabilities is a joint goal of the child care and disability communities, and they both participate in Individual and Family Support Plans meetings. All existing resources must be re-examined and used to their fullest extent possible. We also need dedicated funding for those additional child care costs required to serve some children with disabilities that are not covered through existing resources.

Now is the time to get involved. With the passage of the school readiness legislation, communities are now involved in developing local coalitions in order to serve young children. Make your voice heard in advocating for quality inclusion programs in your community.

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LISTEN to the children

LISTEN ... to what children say!
Bend down, reach out and kneel,
Take time from busy play;
Learn how they feel
About the world today.

LISTEN ... to what children say!
They laugh and chatter,
Simple games they play each day.
World problems do not matter,
The present's where they stay.

LISTEN ... to what children say!
They love and share their promise
in a timely way;
They seem to show no care
for where their heads they lay.

LISTEN ... to what children say!
Deep down inside and out of sight,
A voice, from far away, says:
"All's not right for those
with whom they stay."

LISTEN ... to what children say!
With glisten in their eyes,
They make believe their play;
No person to despise,
No poison, no decay.

LISTEN ... to what children say!
Bend down, reach out and kneel.
Time out from busy play;
Learn how they REALLY feel..
About the world today.

Jim Powell, Ed.D., Consultant, Kaplan Companies, Opp, Alabama.

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If You Offer Inclusion Training, They Will Come!

Susan Gold, Ed. D., Principal Investigator
Scot Liepack, M.S.
Michele D. Scott, M.S.
Sheena Benjamin-Wise, B.A.

This article presents the elements in our inclusion training programs that respond to the needs, concerns, and hopes of the child care providers. The training programs were designed to educate child care providers who facilitate inclusion, with the two objectives of enrolling children with special needs into child care centers and increasing the quality of child care for all enrolled children. At the end of three years, over 200 child care providers have participated in inclusion training and approximately 100 children with special needs have been enrolled. Our keys to success were fourfold: the ability and sensitivity of the lead trainer and the approachability of the guest speakers, the enthusiastic support of the administrators of the child care centers, the technical assistance provided to each center by the project staff, and the word of mouth endorsement by those who have received the training. Inclusion training is important and fun!

If You Offer Inclusion Training, They Will Come!

There has recently been significant discussion about bridging the research to practice gap in inclusionary child care (Carnine, 1997). As part of a University Affiliated Program (UAP) that conducts inclusion training for child care providers, we cross that bridge daily. Although substantial research has been conducted documenting the benefits and challenges of implementing inclusion programs in preschools (i.e. Bricker, 1995; Buysse & Bailey, 1993; Guralnick, 1990), the experiences of the neighborhood child care provider have been notably absent from most of the inclusion literature. We stand in a position, and with a responsibility, to help reflect their voice. The perspective of the child care provider is an important component of a comprehensive research perspective and we have an active commitment to modify our training practices to be increasingly responsive to the needs of the providers. This article presents our insights about the human elements that we included in our training, responding to the needs, concerns, and hopes of child care providers.

We are now beginning our third funded grant for inclusion training, offered through the Mailman Center for Child Development at the University of Miami, School of Medicine. The primary goal has been providing meaningful training to child care providers in order to develop their understandings, skills, and competencies in working with children with special needs and their families. The programs were designed to educate child care providers who would facilitate inclusion, who would feel knowledgeable and at-ease with children with special needs, and who would be able to communicate this knowledge and acceptance to the children and their parents. Included in this goal were two objectives: to enroll children with special needs into the child care centers at the completion of training, and to increase the quality of child care for all enrolled.

Recruitment

Announcements concerning "FREE" training were made at meetings in our community including: the Interagency Coordinating Council, the monthly director's meeting held for centers receiving subsidized child care, and the local NAEYC affiliate. Articles were also written for local newsletters read by child care providers. Initial presentations were made at several child care centers, urging providers to attend the training. There were no strings attached. Centers didn't have to promise to admit children with

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special needs into their centers, they just had to promise to complete the training. We even offered to pay for substitute teachers so centers would not jeopardize their licenses if an inspector happened to drop by. Finally, training was held at nap time and in a central location in order to facilitate attendance.

First Session:

We prepared a wonderful presentation for our first session and only seven participants showed up. We were quite disappointed, but hopefully it didn't show. We went ahead as if the room were filled to capacity and we vowed to continue our recruiting efforts.

Three Years Later:

Over 200 child care providers, from sixty childhood centers, have now participated in inclusion training. Approximately 100 children with special needs have been enrolled in the child care centers, either part-time or full-time, during or following training, representing approximately 10% of the total child enrollment. Over the last three years our training projects have generated enough enthusiasm and publicity that we now have a waiting list of centers and child care homes wanting to participate in training.

The Force of Inclusion

Inclusion supports the rights of all children, regardless of their diverse abilities, to be active participants within their own communities (DEC, 1993). Inclusion means the full integration of children with special needs into a neighborhood environment, such as a child care center, in a setting that is representative of the child's socio-cultural environment, and that emphasizes the positive aspects of that environment.

The force of inclusion comes, in part, from its roots. The Americans With Special Needs Act (ADA) is civil rights legislation that provided the foundation of equal opportunity for people with special needs. The Individuals with Special Needs Education Act (IDEA) is education legislation that mandates free and appropriate education in the least restrictive environment. These acts form the foundation in legislation that supports the move to inclusionary options. Resistance to the option of inclusion, at an individual as well as at a systemic level, reminds us of the resistance to racial integration. In our reaching out to the community to provide education about the rights and abilities of children with special needs, we have encountered a lot of fear, much of it very similar to the genuine concerns that were raised about integration. However, our experience has also been that when people who care about children are exposed to children with special needs they begin to see the many similarities among all children. Very quickly, a child's disability simply becomes another individual difference.

The multidisciplinary nature of our group allows us to bring multiple perspectives to issues of inclusion. We represent backgrounds in early childhood education, school and clinical psychology, and counseling, yet surprisingly no one on our team had prior training in early childhood special education. All of us came to this point because within our separate areas we were drawn to working for and with children with special needs. This also meant that none of us came to our work trained in a framework of "disability." We were all trained in different models that tended to emphasize an orientation to ability nurtured through developmentally appropriate practices. Now, with the emerging emphasis on the whole child and natural environments in special education, we are finding an exciting unity that is being reflected in our training programs.

Keys to Success

Attracting child care providers to inclusion training is only the first step. Maintaining their commitment of continued training is the second. We found several "keys" that were critical to maintaining this commitment.

First was the ability and sensitivity of the lead trainer. Her attitude was supportive and non-judgmental. She was present at every session to lend continuity to the program, even when a guest speaker who was an expert on a particular topic was invited. None of these guest speakers came across as unapproachable. Even though many were faculty at our medical school, they were informative without being either too esoteric or basic. In addition, each session was fun and consisted of several hands on activities and exercise. (See sidebar for a list of titles for each session.).

Titles of the 13 Training Sessions

- Introduction and Individual Education Plans
- Rationale and Philosophy of Inclusion
- MITCH 3: The Child Who Seems Different: Meeting Special Needs
- Developmentally Appropriate Practices
- MITCH 1: Intellectual Development: What You Can Do To Help
- Adapting the Classrooms
- Social Interaction and Teamwork
- The Next Step
- Behavior Management: Preventing and Dealing with Problem Behavior
- Speech and Language Development
- Listening and Sensory Integration
- Infection Control and Seizure Management
- The Caregiving Environment

If You Offer Inclusion Training, They Will Come!

Second, was the enthusiastic support of the administrators of the child care centers. We found that the more involved, interested and committed the administration was, the better the attendance. In fact, those centers with the best attendance were those where the center director actually accompanied the staff to training sessions.

Third, was the technical assistance provided to each center by the project staff. Each trainee was treated as an individual and time was taken to get to know each participant. In addition, as trust was established, project staff was asked for help dealing with individual children and their families. Often it was a matter of simply being on the other end of the telephone, listening as a teacher or center director talked about a concern. This act of listening and supporting was often all that was needed. The trainees needed our validation that they were doing the right thing for the child. We arranged screenings and evaluations, when necessary. We conducted on-site observations so we could help teachers make accommodations for individual children in their classrooms and recommended therapists, if needed. We offered articles and textbooks and made recommendations of special equipment. Being part of a medical school allowed us to find answers to many questions for our participants.

Last, because we supported the education, growth, and self-esteem of our adult learners, they spread the word in the communities that inclusion training was important. We made training fun, using handouts, videos, providing training in the child care providers' native language, and presenting certificates honoring the participants accomplishments. They brought their friends and co-workers with them and over the years our classes have expanded. What began as a project to educate child care providers in a select number of settings has developed into a community collaboration, and has resulted in an increased awareness of equal opportunity for all children.

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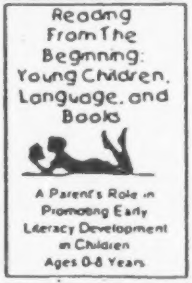
Position Statement on Developmentally Appropriate Programs for Young Children



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Creating *Inclusive* Classrooms:

A Report From the Field

Susan Gold, Ed.D., Scott Liepack, Ph.D.,
Michele Scott, Ph.D., and **Sheena Benjamin-Wise, B.S.,**
Mailman Center for Child Development, University of Miami

Every day in this country, parents leave 13 million of their young children with caregivers who are not family members. In spite of parents' best efforts to meet the needs of their children, the lack of high-quality options for child care means that 80% of these children spend their days in child care centers and family child care homes that are poor to mediocre in quality (Kagan & Cohen, 1997). Poor quality child care is a particularly acute problem for children with special needs. The lack of safe, healthy, and nurturing environments for children with disabilities or who are at-risk may seriously compromise their long-term development (Ibid., 1997). Meeting the needs of children with disabilities and their families presents a continuing challenge for child care providers. This article describes a training program that evolved into a model demonstration program developed to achieve high-quality inclusive child care in Miami, Florida that has great generalizability—across the country.

Contemporary models of inclusion are based on the concept of developmentally appropriate practice and emphasize high quality. Inclusion begins with the assumption that children with disabilities will participate actively in neighborhood settings representative of the positive aspects of the children's socio-cultural environment (Bredekamp & Copple, 1997; DEC, 1993; Wolery & Wilbers, 1994). For a community to weave together the patchwork of child care services into an inclusive high-quality quilt, child care providers, parents, center directors, inclusion facilitators, special educators, and researchers must all work together (Carnegie Corporation, 1994).

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Vignettes

Ms Rivera, the mother of three-year old Tommy, recently telephoned the Best Child Care Center to ask for information concerning placing her son in child care. She was very nervous on the phone, cautiously mentioning that Tommy has Down Syndrome. After carefully looking at their enrollment, the director of Best Child Care realized they had no openings at that time. Although the director knew that, by law, she was supposed to admit children with disabilities, she also felt some relief that, at least for now, they would not have to accommodate a child who was "different." Still, she wondered if it might not be better for everyone involved if the children in her center were exposed to children with disabilities in a way that was very natural.

Ms. Williams, a teacher at Children First Early Learning Center, recently requested a transfer to the two-year old class, although she had always loved working with four-year olds. The Center director wondered if the request was prompted by Jo, an active four-year old girl who had just been diagnosed with a disability. In addition to the transfer request from Ms. Williams, some of the other children's parents were already expressing concern about the impact of Jo's disability on their own children. The Center director was concerned that, by continuing to include Jo in the classroom, some families might leave and the Center might eventually lose one of its best teachers. The director felt an obligation to Jo and her parents and recognized that inclusion was the law (i.e., Americans with Disabilities Act, P.L. 101-336). Ms. Williams did feel bad about her desire to transfer, and her response to Jo made her wonder if it was time for her to quit teaching young children. Finally, all the rest of the staff knew about this quandary and opinions about what to do were becoming a divisive issue among them. Yet it is often this type of crisis that prompts our being called on to help a center meet the requirements of the law and the needs of its customers.

Our Objectives

The Preschool Inclusion Projects began in 1994 by implementing a training curriculum about inclusion and child development for preschool teachers in seven child care centers. The objectives of the project were to educate child care providers who would facilitate inclusion, who would feel knowledgeable and at-ease with children with disabilities, and who would be able to communicate this knowledge and acceptance to the children's parents.

At first we thought a trained child care provider would be the critical element for the success of an inclusion program for young children. However, our experiences over the past five years with an increasing number of child care centers have demonstrated that only providing inservice training for child care providers is not sufficient to attain high quality child care for children. Although still emphasizing the original focus on providing training to center-based child care providers, our training program has evolved to consist of the following interrelated elements.

1. A Comprehensive Training Curriculum

It is widely accepted in the field that child care providers need training to understand the various aspects of quality and to create high-quality settings (Cost, Quality, & Child Outcomes Study Team, 1995). Training also is needed to effectively include children with special needs (Aguirre, 1987; Bricker & Cripe, 1992; Frank, Keith, & Steil, 1998). There are also strong indications that the more broad-based training and education child care providers have, the more skilled they are at helping children thrive (Kagan & Cohen, 1997). The questions and comments during and after training sessions supported these research findings and let us know that caregivers needed a comprehensive training program that included conceptual, theoretical, and practical information.

Our training had always contained modules on typical and atypical child development, creating high-quality classrooms, adapting classrooms to better serve

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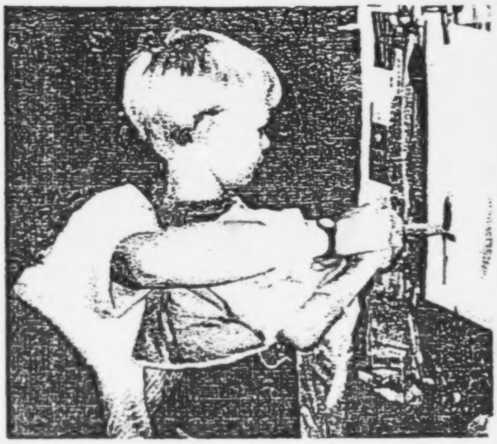

had to be an active participant in the training program. First, when the director attended, a statement about the importance of training was made to the rest of the staff. Not only were those participants attending with their director more focused and attentive during the training sessions, but centers where the director attended training admitted children with special needs more quickly than centers whose directors did not participate. Second, when an administrator participated there were fewer problems with teachers not being able to attend training because of demands at the centers. We also learned that in cases in which final decision making was vested in a different owner or a board of directors, the owner or directors also had to agree to make their center inclusive.

Another issue of concern is the widespread lack of national accreditation (Kagan & Cohen, 1997). Although there are more than 1,300 licensed child care facilities in Miami-Dade County, only 31 are currently nationally accredited. The original assumption was that with training, the offer to pay accreditation fees, and our general support, accreditation would naturally follow. For the most part this has not occurred. Many of the directors report that, although they would like to have their centers accredited, they have felt overwhelmed by the accreditation self-study process and the time needed to complete it. Considering that national accreditation is, perhaps, the most commonly accepted indicator of quality, we are now providing center director mentors to help with accreditation and staff development. One unexpected indicator of the benefits of training was that many of the center directors who had completed training volunteered to be a center director mentor to help others with inclusion and accreditation procedures.

4. A Focus on Family-Home Child Care Providers

The revisions in curriculum, the provision of mentors, and meeting the needs of center directors yielded a model that met many of the initial goals of training. However, even with these changes in the model, we realized that in order to provide high-quality care that would yield a beneficial and long-lasting impact on all our community's children, our model needed to be expanded again. There is a pronounced lack of availability of infant/toddler care in our community. The trend nationwide is to place these youngest children with home-based child care providers (Auerbach & Woodill, 1992). We therefore began to develop a training component for these providers.

When our model first expanded to include family-home child care providers, it quickly became clear that we had not understood their unique requirements. Special consideration had to be given to differences in the needs and constraints of home-based providers from those in centers. While a center could make arrangements to allow its staff to attend training, home-based providers were understandably reluctant to leave their in-home business in the care of another person. We agree with Baker (1997) that the in-home trainer-mentor model is working

... [M]any of the center directors who had completed training volunteered to be a center director mentor to help others with inclusion and accreditation procedures.

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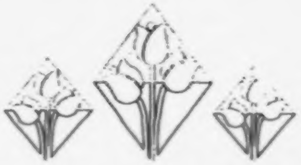
The Enterprise Zone-Preschool Inclusion Project

Research Protocols

Research Protocols

- Informed Consents
- Sample EZ-PIP Training's Pre and Post Tests
- Abbott-Shim, M. & Sibley, A. (1994). Assessment Profile for Early Childhood Programs
- Bailey & Winton. (1987). Benefits and Drawbacks of Early Childhood Inclusion.
- Bailey & Winton. (1987). Adapted from Benefits and Drawbacks of Early Childhood Inclusion, Revised.
- Burton, C. (1992). Family Involvement Survey.
- Wesley, P. & Buysse, V. (1994). Self-assessment for Child Care Professionals.
- Odom, S., et al (1988). Teacher Rating Scale of Social Interaction.
- Hresko, W.P., Miguel, S. A. , Sherbenou, R. J., & Burton, S. D. (1990) *Developmental Observation Checklist System*. Austin, TX: Pro-Ed Inc.



Informed Consents

Print your 6-digit **ID Number** here (first name and last name initials plus the last four digits of your social security number: _____ _____ - _____ _____ _____ _____

Informed Consent

Dear Child Care Center Director:

Purpose:
We would like for you to be part of a study on the effectiveness of inclusion training being offered to child care providers in Miami-Dade County. The program is called the Enterprise Zone-Preschool Inclusion Project (EZ-PIP). The program was developed because there is great need to serve children with disabilities in Miami-Dade County and many child care providers feel that they do not have enough training on how to optimize the development of these children. This program will provide such training as well as helping to expand the opportunities of children with special needs to attend quality child care programs in their neighborhoods. Your participation in this study will help us document the impact of our training programs.

Procedure:
If you agree to be in the study, you will be involved in filling out questionnaires and invited to join in the training. You will be asked to fill out information at the beginning and the end of training. These questionnaires ask about your beliefs and attitudes about children with special needs and about what you do with the children in your Center. The time involved in answering the questions will generally not exceed 1 hour at each of the two sessions. Participation in the project includes the attendance of staff development sessions that may occur during your workday. These consist of approximately five two-hour meetings per year. Inclusion training will consist of 12 two-hour sessions. At each training session, should you participate in them, you will be given a short quiz about the day's material. In addition we will ask for demographic information about your center's teachers and children who attend. This information will also be confidential and nothing will be asked that will link this information to any specific person or named center.

Risks:
There are no risks to you for participating in this study.

Benefits:
You will be provided training in inclusionary and developmentally appropriate practices. Your center will be provided assistance in obtaining national accreditation.

Alternatives:
Participation in this project is completely voluntary. You can withdraw from participating in EZ-PIP at any time. Should you say "Yes" and later change your mind, you have the right to withdraw your consent. If you do not participate or withdraw from participation, it will have no effect on your work as a child care provider.

Confidentiality:
If you decide to participate in EZ-PIP, all information will be stored by number only and will be kept confidential to the full extent permitted by law. Your records may also be reviewed for audit purposes by authorized University employees or other agents who will be bound by the same provisions of confidentiality. The Department of Health and Human Services may also review these research records. The results of the study will be published as group data without reveling the identity of any participant.

Questions:
You may ask and will receive answers to any questions related to this study. If you have any questions about this study, please feel free to contact Dr. Susan Gold at 305 243-6624. If you have any questions about your rights as a research subject, you may contact Maria Arnold, Institutional Review Board Administrator at 305 243-3327.

_______________________________ _______________________________
Subject's Signature Date

In addition to participating in the research protocol specified above, the following items specify the additional obligations of full participation in the Enterprise Zone-Preschool Inclusion Project. Please read them carefully:

1. I will continue to meet on a scheduled basis with other family child care providers included in the Enterprise Zone-Preschool Inclusion Project and to participate in training offered by the Mailman Center for Child Development.
2. Parent training sessions concerning inclusion of children with special needs in family child care settings will be held during the school year. I will encourage parents of the children in my care to attend these training sessions and will support them by attending the training sessions myself.
3. If I have not already done so, I will consider taking and successfully completing the 10-hour Mainstreaming Works! Child-Care course developed by the Department of Children and Families.
4. I will participate in the evaluation of the Enterprise Zone-Preschool Inclusion Project. I will also encourage the parents of children in my care to consider participating in the evaluation of the Project.
5. I understand credit for this training can be applied toward a National Child Development Associate Credential and will aid in the National Association for Family Child Care Accreditation process. I will actively consider achieving both my own credentials and accreditation for my family child-care home.

I have read and had the opportunity to h\ask questions and I understand the above statements as they pertain to my participation in the EZ-PIP program.

Initials:_______________

Date:_______________

Print your 6-digit **ID Number** here (first name and last name initials plus the last four digits of your social security number: _____ _____ - _____ _____ _____ _____

Informed Consent

Dear Child Care Provider:

Purpose:
We would like for you to be part of a study on the effectiveness of inclusion training being offered to child care providers in Miami-Dade County. The program is called the Enterprise Zone-Preschool Inclusion Project (EZ-PIP). The program was developed because there is great need to serve children with disabilities in Miami-Dade County and many child care providers feel that they do not have enough training on how to optimize the development of these children. This program will provide such training as well as helping to expand the opportunities of children with special needs to attend quality child care programs in their neighborhoods. Your participation in this study will help us document the impact of our training programs.

Procedure:
If you agree to be in the study, you will be involved in filling out questionnaires and in training. You will be asked to fill out information at the beginning and the end of training. These questionnaires ask about your beliefs and attitudes about children with special needs and about what you do with the children in your classroom or child care home. The time involved in answering the questions will generally not exceed 1 hour at each of the two sessions. In addition we will observe your classroom for approximately 1 hour over a four-hour period on two separate occasions and fill out an observation form and a rating scale. You will receive a copy of this consent form.

Risks:
There are no risks to you for participating in this study.

Benefits:
You will be provided training in inclusionary and developmentally appropriate practices and will be given a certificate documenting the successful completion of this continuing education program.

Alternatives:
Participation in this project is completely voluntary. You can withdraw from participating in EZ-PIP at any time. Should you say "Yes" and later change your mind, you have the right to withdraw your consent. If you do not participate or withdraw from participation, it will have no effect on your work as a child care provider.

Confidentiality:
If you decide to participate in EZ-PIP, all information will be stored by number only and will be kept confidential to the full extent permitted by law. Your records may also be reviewed for audit purposes by authorized University employees or other agents who will be bound by the same provisions of confidentiality. The Department of Health and Human Services may also review these research records. The results of the study will be published as group data without reveling the identity of any participant.

Questions:
You may ask and will receive answers to any questions related to this study. If you have any questions about this study, please feel free to contact Dr. Susan Gold at 305 243-6624. If you have any questions about your rights as a research subject, you may contact Maria Arnold, Institutional Review Board Administrator at 305 243-3327.

_______________________ Subject's Signature

_______________________ Date

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Print your 6-digit **ID Number** here (first name and last name initials plus the last four digits of your social security number: _____ _____ - _____ _____ _____ _____

Informed Consent

Dear Family Child Care Provider:

Purpose:
We would like for you to be part of a study on the effectiveness of inclusion training being offered to child care providers in Miami-Dade County. The program is called the Enterprise Zone-Preschool Inclusion Project (EZ-PIP). The program was developed because there is great need to serve children with disabilities in Miami-Dade County and many child care providers feel that they do not have enough training on how to optimize the development of these children. This program will provide such training as well as helping to expand the opportunities of children with special needs to attend quality child care programs in their neighborhoods. Your participation in this study will help us document the impact of our training programs.

Procedure:
If you agree to be in the study, you will be involved in training and in filling out questionnaires. Initial training will consist of 16 two-hour sessions. Additional training will consist of 13 two-hour inclusion training sessions to be held over a two-year period. You will be asked to fill out information at the beginning and the end of training. These questionnaires ask about your beliefs and attitudes about children with special needs and about what you do with the children in your family child care home. The time involved in answering the questions will generally not exceed 1 hour at each of the two sessions. In addition, we will observe your home for approximately four hours and fill out an observation form and a rating scale. You will receive a copy of this consent form.

Risks:
There are no risks to you for participating in this study.

Benefits:
You will be provided training in inclusionary and developmentally appropriate practices and will be given a certificate documenting the successful completion of this continuing education program. You will also be provided assistance in obtaining accreditation from a national accrediting organization.

Alternatives:
Participation in this project is completely voluntary. You can withdraw from participating in EZ-PIP at any time. Should you say "Yes" and later change your mind, you have the right to withdraw your consent. If you do not participate or withdraw from participation, it will have no effect on your work as a child care provider.

Confidentiality:
If you decide to participate in EZ-PIP, all information will be stored by number only and will be kept confidential to the full extent permitted by law. Your records may also be reviewed for audit purposes by authorized University employees or other agents who will be bound by the same provisions of confidentiality. The Department of Health and Human Services may also review these research records. The results of the study will be published as group data without reveling the identity of any participant.

Questions:
You may ask and will receive answers to any questions related to this study. If you have any questions about this study, please feel free to contact Dr. Susan Gold or Michele D. Scott at 305 243-6624. If you have any questions about your rights as a research subject, you may contact Maria Arnold, Institutional Review Board Administrator at 305 243-3327.

_______________________ Subject's Signature

_______________________ Date

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In addition to participating in the research protocol specified above, the following items specify the additional obligations of full participation in the Enterprise Zone-Preschool Inclusion Project. Please read them carefully:

1. I will continue to meet on a scheduled basis with other family child care providers included in the Enterprise Zone-Preschool Inclusion Project and to participate in training offered by the Mailman Center for Child Development.
2. Parent training sessions concerning inclusion of children with special needs in family child care settings will be held during the school year. I will encourage parents of the children in my care to attend these training sessions and will support them by attending the training sessions myself.
3. If I have not already done so, I will consider taking and successfully completing the 10-hour Mainstreaming Works! Child-Care course developed by the Department of Children and Families.
4. I will participate in the evaluation of the Enterprise Zone-Preschool Inclusion Project. I will also encourage the parents of children in my care to consider participating in the evaluation of the Project.
5. I understand credit for this training can be applied toward a National Child Development Associate Credential and will aid in the National Association for Family Child Care Accreditation process. I will actively consider achieving both my own credentials and accreditation for my family child-care home.

I have read and had the opportunity to h\ask questions and I understand the above statements as they pertain to my participation in the EZ-PIP program.

Initials:_______________

Date:_________________

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Print your 6-digit **ID Number** here (first name and last name initials plus the last four digits of your social security number: _____ _____ - _____ _____ _____ _____

Informed Consent

Dear Mentor:

Purpose:
We would like for you to be part of a study on the effectiveness of inclusion training being offered to child care providers in Miami-Dade County. The program is called the Enterprise Zone-Preschool Inclusion Project (EZ-PIP). The program was developed because there is great need to serve children with disabilities in Miami-Dade County and many child care providers feel that they do not have enough training on how to optimize the development of these children. This program will provide such training as well as helping to expand the opportunities of children with special needs to attend quality child care programs in their neighborhoods. Your participation in this study will help us document the impact of our training programs.

Procedure:
If you agree to be in the study, you will be involved in filling out questionnaires and in training. Training will consist of approximately ten 2-hour sessions for each year you serve as a mentor. Participation in the project includes the attendance of staff development sessions that may occur during your workday. You will be asked to fill out information at the beginning and the end of training. These questionnaires ask about your experiences of being a mentor. The time involved in answering the questions will generally not exceed 1 hour. You will receive a copy of this consent form.

Risks:
There are no risks to you for participating in this study.

Benefits:
You will be provided training in mentoring and will be given a certificate documenting the successful completion of this continuing education program.

Alternatives:
Participation in this project is completely voluntary. You can withdraw from participating in EZ-PIP at any time. Should you say "Yes" and later change your mind, you have the right to withdraw your consent. If you do not participate or withdraw from participation, it will have no effect on your work as a child care provider.

Confidentiality:
If you decide to participate in EZ-PIP, all information will be stored by number only and will be kept confidential to the full extent permitted by law. Your records may also be reviewed for audit purposes by authorized University employees or other agents who will be bound by the same provisions of confidentiality. The Department of Health and Human Services may also review these research records. The results of the study will be published as group data without reveling the identity of any participant.

Questions:
You may ask and will receive answers to any questions related to this study. If you have any questions about this study, please feel free to contact Dr. Susan Gold at 305 243-6624. If you have any questions about your rights as a research subject, you may contact Maria Arnold, Institutional Review Board Administrator at 305 243-3327.

_____________________________ Subject's Signature

_____________________________ Date

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Print your 6-digit **ID Number** here (first name and last name initials plus the last four digits of your social security number: ____ ____ - ____ ____ ____ ____

Informed Consent

Dear Parent:

Purpose:
We would like for you and your child to be part of a study on the effectiveness of inclusion training being offered to child care providers in Miami-Dade County. The program is called the Enterprise Zone-Preschool Inclusion Project (EZ-PIP). The program was developed because there is great need to serve children with disabilities in Miami-Dade County and many child care providers feel that they do not have enough training on how to optimize the development of these children. This program will provide such training as well as helping to expand the opportunities of children with special needs to attend quality child care programs in their neighborhoods. Your participation ad your child's in this study will help us document the impact of our training program.

Procedure:
If you agree to be in the study, you will be involved in filling out questionnaires relating to you and your child. You will be asked to fill out questionnaires about your beliefs and attitudes about children with special needs. If you have a child with special needs you will also be asked questions specifically related to caring for your child. You will be asked to complete this information at the beginning and at the end of our child care provider training program, approximately 12 months apart. The time involved in answering the questions will generally not exceed 1 hour at each of the two sessions. You will receive a copy of this consent form.

Risks:
There are no risks to you for participating in this study.

Benefits:
There is no direct benefit to you or your child for your participation in this study.

Alternatives:
Participation in this project is completely voluntary. You can withdraw from participating in EZ-PIP at any time. Should you say "Yes" and later change your mind, you have the right to withdraw your consent. If you do not participate or withdraw from participation, it will have no effect on your work as a child care provider.

Confidentiality:
If you decide to participate in EZ-PIP, all information will be stored by number only and will be kept confidential to the full extent permitted by law. Your records may also be reviewed for audit purposes by authorized University employees or other agents who will be bound by the same provisions of confidentiality. The Department of Health and Human Services may also review these research records. The results of the study will be published as group data without reveling the identity of any participant.

Questions:
You may ask and will receive answers to any questions related to this study. If you have any questions about this study, please feel free to contact Dr. Susan Gold at 305 243-6624. If you have any questions about your rights as a research subject, you may contact Maria Arnold, Institutional Review Board Administrator at 305 243-3327.

______________________________ Subject's Signature

______________________________ Date

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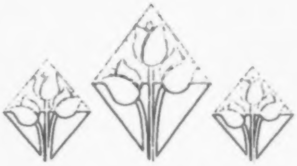

Sample EZ-PIP Training Pre and Post Tests

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ENTERPRISE ZONE – PRESCHOOL INCLUSION PROJECT (EZ-PIP)
SESSION 2

__ PRE-TRAINING __ POST-TRAINING

Your responses to the following questions will help us improve the quality and content of the training sessions. Please take a few minutes to respond to the following questions.

Print your 6-digit ID Number here (first name and last name initials plus the last four digits of your social security number): ____ ____ - ____ ____ ____ ____

Today's Date: _____- ____ - _____ Time ______: _____ AM/PM

CIRCLE ONLY ONE BEST ANSWER FOR EACH QUESTION

1. Where does American government direct most of it's funding
   - a) quality child care programs
   - b) special education programs
   - c) prisons and rehabilitative programs
   - d) Department of children and families
   - e) All of the above

2. When does a person have the most brain cells
   - a) newborn
   - b) 1 years old
   - c) 20 years old
   - d) 35 years old
   - e) none of the above

3. The brain does not control which of the following:
   - a) breathing
   - b) vision
   - c) speaking
   - d) an itch
   - e) none of the above

4. Chronic ear infections affect
   - a) hair growth
   - b) maturity
   - c) language
   - d) vision
   - e) All of the above

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5. Touch and massaging help
    a) cognitive
    b) emotional
    c) physical
    d) bonding with their parent
    e) all of the above

6. Children who go to quality child care programs. Will probably go to:
    a) college
    b) get arrested
    c) drop out of high school
    d) need the assistance of government funds
    e) none of the above

7. Researchers have found the more words a baby hears, as the baby grows
    a) her language skills improves
    b) she develop a large vocabulary
    c) her ability to express thoughts, ideas and information increases
    d) her ability to master social skills increases
    e) all of the above

8. If the brain is not stimulated,
    a) there is no affect on the child's brain
    b) the brain dies
    c) the child grows up to be an "A" student
    d) the senses develops normally
    e) All of the above

9. The brain burns
    a) 200 calories a days
    b) 300 calories a days
    c) 400 calories a days
    d) 1000 calories
    e) none of the above

10. When should a parent begin to read to their child
    a) newborn
    b) first grade
    c) second grade
    d) when the child wants
    e) all of the above

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PLEASE DO NOT MARK HERE
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ENTERPRISE ZONE-PRESCHOOL INCLUSION PROJECT (EZ-PIP)
SESSION 3

☐ PRE-TRAINING ☐ **POST-TRAINING**

Your responses to the following ten questions will help us improve the quality and content of the training sessions. Please take a **few minutes** to respond to the following questions.

Print your 6-digit **ID Number** here (first name and last name initials plus the last four digits of your social security number): ____ ____ - ____ ____ ____ ____

Today's Date: _____ (MONTH) - _____ (DAY) - ____ (YEAR) Time: _____ (HOUR) : _____ (MINUTE) P.M.

CIRCLE ONLY ONE BEST ANSWER FOR EACH QUESTION

1. Child Find is
   - a. a service to find intellectually gifted preschoolers
   - b. a way to find lost children
   - c. a system that tries to find children who may need special services
   - d. all of the above
2. Which of the following is NOT a prenatal risk factor
   - a. stress of the mother
   - b. age of the mother
   - c. method of delivery
   - d. genetic problems

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3. Related services refer to

   a. caregiving by a relative

   b. inclusion

   c. physical therapy

   d. free and appropriate education

4. Sensory impairment refers to

   a. mental retardation

   b. poor speech

   c. low birth weight

   d. problems seeing or hearing

5. The following are benefits of inclusion for typically developing children

   a. enhanced self-worth by being role models

   b. tendancy to become more understanding and sensitive

   c. learns how to develop friendships by caring and sharing

   d. all of the above

6. Special education means

   a. a child is receiving therapy (speech, physicl and/or occupational)

   b. adapting instruction to meet the unique needs of specific children

   c. more work for the teacher

   d. needing special equipment in your classroom

7. An example of a sensory disability is

   a. a health impairment

   b. cerebral palsy

   c. a visual impairment

   d. all of the above

8. An example of a developmental disability is

   a. a hearing impairment

   b. mental retardation

   c. a speech/language disability

   d. all of the above

9. An example of a related service is

   a. a homebound teacher

   b. a PPEC (Pediatrically Prescribed Educational Center)

   c. speech therapy

   d. free lunch

10. An example of a prenatal factor that can put a child "at risk" for developing a disability is

    a. lack of infant stimulation

    b. lack of love

    c. smoking by the mother

    d. all of the above

END

Thank you for your participation.

****

PLEASE DO NOT MARK HERE

Test Score # Correct __ __ Scored By – Initials only __ __

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ENTERPRISE ZONE – PRESCHOOL INCLUSION PROJECT (EZ-PIP)
SESSION 5

__ PRE-TRAINING __ POST-TRAINING

Your responses to the following questions will help us improve the quality and content of the training sessions. Please take a few minutes to respond to the following questions.

Print your 6-digit ID Number here (first name and last name initials plus the last four digits of your social security number): ____ ____ - ____ ____ ____ ____

Today's Date: _____- ____ - _____ Time ______: _____ AM/PM

CIRCLE ONLY ONE BEST ANSWER FOR EACH QUESTION

1. Normal children
    - a) All act the same way all the time every time
    - b) Are good and listen to the adults in there lives all the time
    - c) Grow and develop at different rates
    - d) Never fight with and/or hug other children
    - e) All of the above

2. What is a screening tool?
    - a) A quick test that is used to find a possibility of a problem
    - b) Something to test high blood pressure
    - c) Keeps the insects from your front porch
    - d) Physically hurts children
    - e) none of the above

3. What is a psychological evaluation?
    - a) Something that can be only administered by a psychologist
    - b) Something that tells how well a child is doing
    - c) A comprehensive test
    - d) Something that can take 1 to 3 hours
    - e) All of the above

4. What are important areas preschool providers should target for screenings?
    - a) Vision and hearing
    - b) Health
    - c) Speech and language
    - d) Cognitive, gross motor, fine motor, social/emotional and self help skills
    - e) All of the above

5. Why is it important for preschool teachers to understand screening processes
    a) To assist in identifying the child who may need more attention
    b) There is no importance
    c) To make teachers work harder
    d) To bond with their children
    e) none of the above

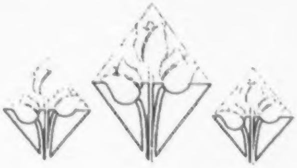
6. What are developmentally appropriate practices?
    a) Sitting the children in high chairs for long periods of time
    b) Letting the child run around the classroom with no structure or guidance
    c) Providing activities for children that are appropriate for their age levels
    d) Time out
    e) none of the above

7. Are preschool teachers able to do classroom observations to help identify children who may need additional attention?
    a) True
    b) False
    c) Not sure

8. Classroom observations
    a) Take a long time
    b) is very complicated
    c) can only be done by qualified personnel
    d) are used to help the teacher focus on different children in the classroom
    e) none of the above

9. The Developmental Observation Checklist system is
    a) a medical injection
    b) a screening tools for providers
    c) a psychological assessment tool
    d) a classroom curriculum
    e) none of the above

10. Early intervention is important in the preschool years because
    a) the earlier the child is identified and served, the better prepared that child will be for public school
    b) it is the law
    c) children like it
    d) teachers need more work to do
    e) none of the above



Assessment Profile for Early Childhood Programs

Assessment Profile
for
Early Childhood Programs

Research Version

Martha Abbott-Shim, Ph.D. Annette Sibley, Ph.D.

Contents

Learning Environment 3
Scheduling 7
Curriculum 9
Interacting 15
Individualizing 17

Program Information

Program Name ______________________

Classroom Identification

					5					10					15					20					25					30
1																														
2																														
3																														

Observation

Beginning Time	Ending Time	Date

Classroom Observers

____

____

____

Clarification of Terms

Learning Environment

A. Items A.1. through A.10. must have a minimum of three (3) different types of materials available to score a "Yes." Examples for each item are listed in parenthesis and begin with "such as . . ." These lists are intended to be samples of materials for each item. Each list is suggestive and is not exhaustive. In addition, these examples represent materials for preschool through primary grade classrooms. Note that three (3) different puzzles would be considered one (1) type of material. Puzzles, legos, and peg boards would be considered three (3) different types of materials. Accessible refers to the location of materials in a manner that the child is able to comfortably obtain and the child has permission to use the material without adult assistance.

A.1. Manipulative materials refers to materials that encourage the development of small muscle, eye-hand coordination.

A.2. Self-help materials are materials that encourage the development of skills that permit the child to take responsibility for self and environment such as dressing frames or dolls that provide experience in learning to zip, button, lace, etc., a watering can that provides experience with caring for plants, a small broom and dust pan for sweeping after art projects or snacks, etc. Note that housekeeping props for imaginative play should not be counted for this item. For example, a wooden iron and ironing board, encourage dramatic play but not the development of ironing skills and, therefore, these props would not be counted in this item.

A.3. Art materials refers to children's art materials versus teacher's art supplies. Large containers of paint or paste (e.g. 16 oz. or larger without a pump), 8-inch pointed scissors, large stacks of paper, etc. are considered teacher's resource supplies and do not qualify. The intent of this item is that art materials are accessible in sizes and volumes that children can comfortably manage.

A.4. Dramatic/role play materials refers to materials that support the dramatization of imagination play, stories, and skits.

A.5. The focus of this item is on science materials that provide the child an opportunity to experiment and manipulate materials. Therefore, display items that cannot be manipulated should not be counted, such as a bird's nest on display. If a pet is present, count it only if the children have an opportunity to feed or otherwise care for the pet and/or there is evidence of active observation of the pet—such as charting the eating, sleeping, growth patterns of the pet. If a pet is present but there is no evidence of active involvement beyond passive observation, do not include the pet in the count.

A.6. Math materials refers to materials that encourage the development of numeracy, mathematical and time concepts.

A.7. Language materials refers to materials that encourage the development of reading, writing, speaking and listening skills.

A.8. Nutrition and health materials refers to materials that encourage the development of healthy practices and good nutrition. Posters and materials/equipment that cannot be manipulated do not qualify.

A.9. A minimum of three (3) different types of materials for a minimum of three (3) different cultures must be represented to score this item "Yes."

A.10. Count repeating labels as only one (1) type of printed language. For example, if the children's cubbies, chairs, and/or places at tables are all labeled with the children's names, this labeling system is one example of printed language. Similarly, if the lego bin and the shelf where the legos are stored are labeled "legos," this system is one example of printed language.

Clarification of Terms

Learning Environment

B.1. Partitions that form physical boundaries may be walls, shelves, a low-free standing bulletin board, etc. that serve to physically separate learning/activity areas within the classroom. Visual separations, boundaries or labels, such as rugs, tape lines, hanging signs, do not qualify. At least three (3) activity areas must be present in the classroom and each area must have at least three (3) partitions or physical separations.

B.2. Conceptually related materials refers to materials that support the child's learning in a specific conceptual area such as art, science, math, etc. The focus of this item is on the organization of conceptual learning areas as evidenced by the collection of various, related, learning materials. For example, in support of learning about artistic concepts, a variety of materials may be grouped together and might include paint and paper, collage materials and paste, art books and sample works of an artist. Note that science materials might be grouped together and also include science books and, possibly, paint and paper if prisms, rainbows, and color are being studied.

B.3. Accessible refers to the presence of materials in a location that a child is able to obtain. Accessibility also refers to the freedom of the child to access materials. The child must be able to obtain and allowed to use materials to score this item "Yes."

B.4. Organized manner refers to the arrangement of learning materials that allows the child clear visibility of individual materials. Different types of learning materials should be individually displayed on a shelf or table, if stacked, no more than two (2) items high and not one in front of the other. This item should be scored on the basis of the dominant mode in the classroom. It is best to determine the dominant mode by counting the individually displayed materials versus the number of materials stacked three (3) or more high and/or one in front of the other. Note that if puzzles are arranged on a puzzle rack, it is acceptable if the bottom puzzle can be pulled out for visibility without unstacking all the puzzles above.

B.5. Places where materials belong may be labeled with pictures, symbols, words, or a combination of these options. Note that this item focuses on the presence of a system of labeling and should be scored on the basis of the dominant mode within the classroom. If the labeling system is predominantly present but appears that it is not used — and this is characteristic of the classroom in general, this item would still be scored "Yes" and item B.4. would be scored "No."

B.6. Self-explanatory.

C.1. A solitary area where one or two children may choose to work alone may be a "reading corner" or an area set out of the way of central classroom activity. The focus of this item is on the option for a child to be involved in an activity alone or with one other child. It is not a "time-out" or punitive place. If this work place is not apparent during observation time, it is acceptable to ask the teacher, "When children choose to work alone, or with one other partner, on a project or activity, where do they work in the classroom?"

C.2. The intent of this item is that child-made work products are displayed and represent individual child effort. These products should be displayed at a child's comfortable eye level, which is considered to be approximately adult head level and below. This item is evidence of how the *classroom reflects the child as an individual.* If the classroom displays are predominantly teacher work or commercially produced posters at child eye level and minimal child work, score this item "No." Note that work samples displayed at the end of string that hangs from the ceiling and is above adult head level would not be considered to be at the child's eye level.

C.3. Diversity refers to the variation in the type (such as writing, constructions, illustrations), the materials, and the content of children's work products. Original refers to those ideas and expressions that originated with the child versus imitations of adult-derived models or directions.

D.1. Self-explanatory.
D.2. Self-explanatory.
D.3. Self-explanatory.
D.4. Self-explanatory.
D.5. Self-explanatory.
D.6. Self-explanatory.

Learning Environment			OBSERVATIONS					
OSPRI	Methods	Standards & Criteria	1		2		3	
			Yes	No	Yes	No	Yes	No
		B. Arrangement of classroom space encourages child independence.						
	O	1. At least three (3) partitions are used to form physical boundaries and definition for at least three (3) learning areas.						
	O	2. Conceptually related materials are organized together (such as art, manipulatives).						
	O	3. Materials for child use are accessible so that children can obtain them without adult assistance.						
	O	4. Materials are displayed in an organized manner.						
	O	5. Places where materials belong are labeled.						
	O	6. Space is arranged to allow at least two of the following types of activities to occur concurrently: full group, small group, and individual.						
		C. Classroom reflects the child as an individual.						
	O,R	1. An area exists in the room where one or two children may choose to work alone.						
	O	2. Children's work is displayed at the child's eye level.						
	O	3. Diversity in children's work products reflect each child's original ideas and/or constructions.						
		D. OUTDOOR play materials and experiences support a variety of learning opportunities.						
	O	1. A variety of materials that encourage large muscle coordination are available to children (such as balls, jump rope, wheel toys).						
	O	2. A variety of materials that encourage manipulation and scientific exploration are available to children (such as water, children's garden tools, sand).						
	O	3. A variety of materials that encourage creativity are available to children (such as art supplies, carpentry supplies, natural resources).						
	O	4. A variety of materials that encourage dramatic play are available to children (such as large house painting brushes, steering wheel mounted on wooden box, camping equipment).						
	O	5. A variety of social activities occur (such as small group and large group games).						
	O	6. Teacher is an active participant outdoors, engaged with children in the use and exploration of motor, science, creative, or dramatic materials.						

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Clarification of Terms

Scheduling

A.1. Written time schedule refers to a general outline of the times and activities of the classroom. The time schedule reflects the overall structure of the day's activities. This schedule may represent a daily schedule of activities or weekly. The schedule must be posted to score "Yes" on this item.

A.2. Lesson plans are specific activity/learning plans. Lesson plans specify a learning topic or theme and include information such as activity procedures, materials to be used, children who will participate, etc. These documents may be posted or in the teacher's files. Score this item "Yes" only if lesson plans are available for at least two (2) previous weeks and, therefore, reflect the continuity of lesson planning over a period of time.

A.3. Learning materials and supplies for activities are ready for use at the time the activity is scheduled. Children do not have to wait while teachers gather and/or prepare materials.

B. Note that B.1. through B.8. are scored on the basis of information contained in the posted, time schedule referenced in A.1. If a written time schedule is not posted, score "No" for items B.1. through B.8.

B.1. Quiet activities refers to scheduled activities in which the children are seated and stationary.

B.2. Active activities refers to scheduled activities in which the children are involved with large motor movement and/or have the option to move about the classroom and interact with materials and others. The focus of this item is on balance between quiet and active activities. It is not necessary for the schedule to reflect a pattern of quiet—active—quiet—active, etc. However, if the schedule is most frequently characterized by a series of two (2) to three (3) quiet activities before an opportunity to move about is scheduled—or vice versa— score this item "No."

B.3. Outdoor activities refer to opportunities for large muscle activity and fresh air. If physical education (P.E.) is indicated on the schedule, ask the teacher to clarify where the activity takes place.

B.4. A minimum of one hour for children to choose and direct their own activities should be reflected in the classroom schedule and may be referred to as *free time, discovery time, learning center time*, or *individual activities*. If reading the schedule is unclear, it is appropriate to ask the teacher to explain the posted schedule of activities. The one hour may be divided in a series of smaller time frames but must cumulatively represent one hour in the classroom. Playground time is not included in the hour, nor is arrival or departure times when *all* children are not present. One hour of child-directed opportunity must be reflected in the schedule within the active program learning time.

B.5. A minimum of one hour of teacher-directed time follows the same guidelines as child directed time in B.4. This hour may be divided in segments, must occur during active program learning time when all children are present, and during classroom time—excluding playground time. During this hour the teacher may be guiding the learning of the full group, a small group, and/or an individual child. Teacher-directed time may occur concurrently with child-directed time if the teacher is engaged with a small group or with an individual child.

B.6. Individual instructional time must be reflected on the written schedule to score this item "Yes." A teacher may work individually with one or two children even though this time is not reflected on the written schedule. If the teacher's individual instructional time is not reflected on the written schedule, score this item "No."

B.7. A small group is a group of three (3) to eight (8) children. If group size is difficult to determine from the written schedule, ask the teacher to clarify the number of children involved in the activities noted on the written schedule.

B.8. Whole group refers to the total classroom population. If group size is difficult to determine from the written schedule, ask the teacher to clarify the number of children involved in the activities noted on the written schedule.

C. Items C.1. through C.5. should be scored on the basis of activities and practices observed during the data collection periods.

C.1. See B.1.
C.2. See B.2.
C.3. See B.7.
C.4. See B.8.
C.5. See B.6.

Scheduling

			OBSERVATIONS					
			1		2		3	
OSPRJ	Methods	Standards & Criteria	Yes	No	Yes	No	Yes	No
		A. Scheduling and planning occur.						
	O,D	1. Written time schedule is posted.						
	D	2. Written lesson plans for previous weeks are available in files.						
	O	3. Teacher has materials and supplies prepared in advance.						
		B. Written schedule reflects variety of activities (if schedule is not posted, mark Criteria 1 through 8, "No").						
	D	1. Posted schedule includes quiet activities (such as seated work, a story time, art and manipulative).						
	D	2. Posted schedule includes quiet activities usually follow active activities.						
	D	3. Posted schedule includes outdoor activities.						
	D	4. Posted schedule includes at least one hour, cumulatively, in which children to choose and guide their own activities.						
	D	5. Posted schedule includes at least one hour, cumulatively, when the Teacher selects and guides the children's activities.						
	D	6. Posted schedule includes daily time when Teacher works individually with one or two children.						
	D,R	7. Posted schedule includes daily time when Teacher works with a small group of three to eight children.						
	D,R	8. Posted schedule includes daily time when Teacher works with the whole group of children.						
		C. Classroom activities reflect variety.						
	O	1. Children are involved in quiet activities (such as seated work, a story time, art and manipulatives).						
	O	2. Quiet activities usually follow active activities.						
	O	3. Daily time occurs when Teacher works with a small group of three to eight children.						
	O	4. Daily time occurs when Teacher works with the whole group of children.						
	O	5. Daily time occurs when Teacher works with one or two children.						

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Assessment Profile for Early Childhood Programs

Clarification of Terms

Curriculum

A.1. Self-explanatory.

A.2. Self-explanatory.

A.3. Self-explanatory.

A.4. Self-explanatory.

A.5. Self-explanatory.

A.6. Self-explanatory.

A.7. Self-explanatory.

A.8. Self-explanatory.

A.9. Self-explanatory.

B.1. Directions refers to instructional explanations.

B.2. Teacher demonstrates a specific sequence of steps for children to follow in working on an activity.

B.3. Activities provide opportunities for children to manipulate materials and/or express their responses with a physical action (such as clapping, following directions to "Simon Says").

B.4. The focus of this item is on the opportunity for the child to work alone or with other children in an activity that reinforces the development of a skill or knowledge which the teacher has previously addressed. The follow-up activity must allow the child some opportunity for choosing how to carry it out. For example, a teacher has led an activity on quantities of "more than" and "less than" using picture cards and pennies for a sorting task. The materials that were used for the activity, or other similar materials, are available for the child to independently work with at a later time. To score this item, following a teacher led activity, observe about the classroom for evidence of materials that are available for child use that reinforce the concepts of the lesson or activity; or observe to see if the teacher makes available the materials used in the activity.

B.5. Factual questions have specific, pre-defined answers, such as "What two colors, when mixed together, make green?"

B.6. Problem-solving questions are open-ended questions that do not have specific, pre-determined answers, but have, instead, multiple, plausible answers.

B.7. Engaging children in language activities refers to involving children in receptive (listening) and expressive (verbal or written) language experiences.

B.8. Integrated learning refers to the inter-relatedness of curriculum content across disciplines and the flexibility of learning experiences in which various media (such as art, science, language materials, etc.) and processes (such as hypothesis testing, reading, discovery through manipulation, etc.) are used to teach a specific concept.

B.9. Minimizes the use of dittos, worksheets, and drills means that either children are not engaged with these forms of materials and activities or for only small amounts of time. When these forms of learning materials and experiences are utilized they are secondary or supplemental in nature to the more active, hands-on teaching/learning strategies.

Curriculum

			OBSERVATIONS					
			1		2		3	
OSPRI	Methods	Standards & Criteria	Yes	No	Yes	No	Yes	No
	R	**A. Teacher fosters awareness and appreciation of diversity.** 1. Teacher can identify the cultural background of all children in the classroom.						
	O,R	2. Teacher provides opportunities for children to share their unique experiences, customs, and traditions through activities, objects, and discussions.						
	O,R	3. Teacher incorporates children's unique experiences, customs, and traditions into classroom activities.						
	O,R	4. Teacher provides activities for children to experience a variety of authentic (not stereotypic) cultural traditions and customs (such as art, music, stories, games, traditional and modern dress, food, living arrangements).						
	O	5. Teacher encourages multi-lingual vocabulary awareness and appreciation.						
	O	6. Teacher provides simple, honest, factual answers to children's questions about others' differences — OR no such questions are asked.						
	O	7. Teacher refrains from making stereotypic remarks and labels (such as "boys don't cry," "the pink ones are for girls," "strong boys and sweet girls").						
	O	8. Teacher refrains from assigning or limiting children's activities on the basis of gender or physical ability (such as "boys don't play with dolls," "girls don't play with trucks").						
	O	9. Teacher encourages children to explore unfamiliar activities, materials, and roles so that they might expand their perceptions of themselves and others.						
	O	**B. Alternative teaching techniques are used to facilitate learning.** 1. Directions are given in clear understandable terms.						
	O	2. Complex activities are demonstrated in an organized sequence of small steps.						
	O	3. Children are encouraged to actively participate in activities.						
	O	4. Teacher-led activities are followed up with independent child-directed opportunities to master specific skills, either through materials or additional activities.						
	O	5. Children are asked questions that require remembering specific facts (such as who, what, when questions).						
	O	6. Children are asked questions that are open-ended or problem-solving (such as why, how, what if questions).						
	O	7. Teacher engages children in language activities (such as reading, story telling, writing child-dictated stories, language games).						
	O	8. Teacher integrates learning by allowing children to explore specific concepts or topics through multiple media and processes.						
	O	9. Teacher minimizes the use of dittos, worksheets, and drills.						

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Clarification of Terms

Curriculum

C.1. The focus of this item is on the process of activities versus products or outcomes of activities. Emphasis is on the opportunities that the teacher provides for children to experiment with activities, ideas, and materials and to seek out information about cause and effect relationships, consequences, and solutions to problems. For example, children may be invited to analyze a story and recommend and/or predict outcomes— or, children may be involved in predicting the outcome of mixing different colors of paint and then experimenting with color mixing.

C.2. The emphasis of this item is on the purposefulness of the materials to teach abstract concepts. For example, marbles can be used to teach abstract concepts of quantity, but the presence of marbles does not indicate that they are used for this purpose unless supporting materials (labeled cards or containers) are present that indicate the marbles are sorted, matched, or counted to illustrate differences in quantity.

C.3. The focus of this item is on the teacher incorporating children's spontaneous ideas into discussions.

C.4. The focus of this item is on the teacher incorporating children's spontaneous ideas into activities.

C.5. The focus of this item is on all children having opportunities to choose among all classroom options. If free choice is only permitted when all children are not present, then score this item "No."

C.6. As children complete a teacher directed activity, they are free to choose another activity and are not required to wait until the full group has finished before going on to another activity.

D.1. This item focuses upon the match between an activity and the skill level of the child and is determined by the level of involvement of the children. If a majority of the children appear to be engaged in teacher-led activities with focused attention and able to accomplish and reach completion of the task, then score this item "Yes." However, score this item "No" if children are clearly unable to perform the steps of teacher-led activities, seem either to complete activities rapidly, appear restless and disinterested, and unable to reach completion of the activity —or complete the activity rapidly with apparent ease.

D.2. The focus of this item is on the teacher allowing ample time for children to complete their work and providing alternative activities for children who complete activities more quickly.

D.3. Modification refers to procedural or material variation within an activity to accommodate differing skill levels of the children. For example, a counting activity may be varied so that some children count larger quantities (counting 10 to 20) while others count smaller quantities (1-10); some children may write captions on their art work using invented spelling, while others dictate their caption for the teacher to record. A procedural modification might also include peer or cross-age tutoring.

D.4. Written communication refers to the child's efforts to form words, letters, or numbers to share information. The emphasis is on communication of information, not on drilled penmanship.

D.5. This item is scored "Yes" if either the teacher or the children are writing to describe experiences and/or pictures. The intent of this item is that individual children have their ideas and experiences expressed in written form.

D.6. Child assessment information from performance inventories or portfolio entries is referenced as the basis for designing activities for individual children that focus on specific skill needs or interests.

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Curriculum

OSPRI	Methods	Standards & Criteria	OBSERVATIONS 1		2		3	
			Yes	No	Yes	No	Yes	No
	O	**C. Children are encouraged to be active in guiding their own learning.** 1. Teacher invites children to compare, solve problems, predict outcomes, and/or manipulate materials to test solutions and predictions.						
	O	2. Children are given opportunities to manipulate and experiment with concrete materials that illustrate or teach abstract concepts (such as shape, size, weight, color, quantity).						
	O	3. Children spontaneously offer suggestions, ideas and interests and the Teacher incorporates them in discussions.						
	O,R	4. Children spontaneously offer suggestions, ideas and interests and Teacher incorporates them into learning activities (such as child is allowed to experiment with materials in alternative uses, an activity is supplemented with additional materials to support child's ideas, new activities are planned and implemented).						
	O	5. All children are allowed opportunities to select their own activities and materials from among all the classroom options.						
	O	6. Children are allowed to choose a new activity upon completion of an activity the Teacher has selected and guided.						
	O	**D. Curriculum is individualized.** 1. Teacher-led activities focus on specific skills the child is currently mastering and are neither too difficult nor too simple.						
	O	2. Children are allowed to work at their own pace so that those who work quickly are allowed to proceed within the activity or to new activities and those who work slowly are allowed ample time to complete the activity.						
	O	3. Activities that involve children of differing skill levels are modified to accommodate variation within the group.						
	O	4. Teacher acknowledges and encourages the child's attempts at, or demonstration of, written communication (such as invented spelling for labels and captions to drawings).						
	O	5. Teacher writes words dictated by children, or children themselves write, to describe an experience and/or ideas.						
	O,R	6. Information from completed child assessments is used to design activities that facilitate the development of specific skills.						

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Clarification of Terms

Curriculum

E. The following items focus on the interpersonal learning experiences among the children and, therefore, examine the interactions between children rather than between teacher and children.

E.1. Collaborative refers to the manner in which the children share information among themselves, incorporate each other's ideas, adopt a common goal, allow for equity in contribution, and generally demonstrate respect for each other's ideas and efforts. The intent of this item is that children have opportunities for these experiences, recognizing that these may be developing skills that may be accomplished with varying degrees of success.

E.2. Children determine the nature of an activity and the steps to carry it out; they may make decisions about roles and related task assignments, such as who will be the leader or recorder.

E.3. Alternative problem-solving strategies refers to a variety of possible solutions or methods for completing an activity or resolving a conflict. The intent of this item is that children have an opportunity to speculate about multiple solutions together and then to carry out a possible solution.

Curriculum

OSPRI	Methods	Standards & Criteria	OBSERVATIONS 1 Yes	OBSERVATIONS 1 No	OBSERVATIONS 2 Yes	OBSERVATIONS 2 No	OBSERVATIONS 3 Yes	OBSERVATIONS 3 No
		E. Classroom activities provide cooperative learning experiences.						
	O	1. Children have an opportunity to work in collaborative partnerships and/or small groups, sharing responsibility for activities.						
	O	2. Children jointly make decisions about the content and/or process of an activity.						
	O	3. Children work together to identify and implement alternative problem-solving strategies.						

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Clarification of Terms

Interacting

A. The emphasis for items A.1. through A.4. is on the teacher's initiation. Each item should be scored on the basis of the characteristic style or mode of the interactions initiated by the teacher. Frequency of occurrence may vary, but isolated events do not qualify.

A.1. Positive physical interactions are intended to be spontaneous and demonstrative of positive affection versus a contact gesture to signal a child or manage behavior.

A.2. Positive verbal interactions focus on specific behaviors rather than generalized characteristics.

A.3. This item focuses on comfortable and happy interactions and includes humor and playfulness initiated by the teacher.

A.4. Conversation refers to the exchange of ideas and information between the teacher and child but has an air of informality and reciprocal dialogue, it is conversational in nature versus instructional.

B. The emphasis for items B.1 through B.3. is on the teacher's responsiveness. Each item should be scored on the basis of the dominant style or mode of the interactions between teacher and children.

B.1. When a child is speaking to the Teacher, the Teacher allows the child to complete the interaction without other children's interruptions.

B.2. Acknowledge refers to the teacher's verbal response which may be a simple response such as "okay" or "yes" or it may be an elaboration of the child's statement—rephrasing and including the child's words or questioning to encourage the child to elaborate. Acknowledge may also refer to a non-verbal, physical response such as a nod of the head, a smile, or a rub on the child's back.

B.3. Acknowledge is clarified under item B.2. above. Child's feelings refers to any affective expression from a child and may be vocal (such as laughing or crying), verbal (such as "I don't like you"), or physical (such as angrily striking another child or lying limp on the floor and rubbing eyes during a story time or smiling and hugging the teacher upon arrival).

C. For items C.1. through C.4., if undesirable behavior is not observed, score the item "Yes."

C.1. Verbally intervenes is any verbal response the teacher makes towards a child that stops undesirable behavior. Undesirable behavior is any child behavior that is disruptive to an activity and/or harmful to the child's own person, others, or the environment. Undesirable is defined in terms of the impact of the child's behavior on self, others, and environment. If the teacher's verbal intervention is scolding or critical then score this item "Yes" and score item C.5. "No." If the verbal intervention serves to redirect the child's behavior to desired behavior, then score this item "Yes" and item C.4. is scored "Yes."

C.2. Consequences refers to natural cause and effect relationships such as "If you leave your art project on the floor someone might step on it." Consequences may also refer to the action that will be taken if undesirable behavior persists. This may be considered a warning but must be stated without critical tone and no more than two (2) times. If consequences are stated more than two times for the same undesirable behavior, the statement of consequences becomes critical in tone and threatening—therefore, score this item "No" and score C.5. "No."

C.3. Consequences in this item refers to consequences that are under the control of the teacher such as "If you continue to disturb John, I will ask you to leave the circle." Consistency refers to the implementation of the consequence in a timely manner so that when the undesirable behavior occurs, the consequence follows immediately. For example, the child is asked to leave as soon as the child disturbs John again. If the consequence is to happen at a later time, the teacher informs the child(ren) that the consequence (such as withdrawing a privilege) will be implemented and then follows through when the time comes.

C.4. Redirect refers to the teacher's efforts to guide the child's attention and/or behavior towards desired actions. For example, if a child is pounding on a truck with a block, the teacher may redirect the undesirable pounding to desirable constructive behavior by joining the child and beginning to build a road and bridge using the block and the truck and involving the child.

C.5. Negative verbalizations refers to any comments that are critical in nature and includes critical tones. Negative verbalizations may be overtly hostile such as "That's a dumb thing to do" or subtle, such as "You're a big boy, now stop crying, boys don't cry" or "You're not being a very good friend when you hit her."

C.6. Social-emotional conflict refers to disagreements between children. Children are encouraged to verbally express their differences of opinion or desires, to negotiate compromises and solutions, to make choices and assume responsibility for their own actions.

D. Score items D.1. through D.3. on the basis of the dominant sounds and interactions of the classroom as children are engaged in activities and tasks.

D.1. Smiling and laughing are signs of children's enjoyment with their interactions with each other and activities. Freely refers to the absence of adult imposed restrictions.

D.2. Cooperation refers to child interactions with each other, the teacher, and the classroom environment such as taking turns and exchanging conversation and materials without conflict. Cooperation in this item is not intended to rely solely on compliance with the teacher's rule. Interactions among children is of equal importance. For example, children who are obeying the rules to be quiet and sit still while waiting for lunch is not sufficient evidence to score this item "Yes."

D.3. Handling refers to focused, purposeful manipulation of materials. Materials are intended to be broadly defined and represent a variety of concrete and representational objects. Paper and pencil exclusively do not qualify.

Interacting

OSPRI	Methods	Standards & Criteria	OBSERVATIONS					
			1		2		3	
			Yes	No	Yes	No	Yes	No
		A. Teacher initiates positive interactions with children.						
	O	1. Teacher initiates positive physical gestures (such as smiles, hugs, pats, holds).						
	O	2. Teacher initiates positive verbal interactions (such as encouragement, affirmations, and acknowledgment).						
	O	3. Teacher engages children in laughter and smiling through verbal exchanges and/or playful games and activities.						
	O	4. Teacher engages children in conversations (such as personal experiences, ideas, plans).						
		B. Teacher is responsive to the children.						
	O	1. Child is allowed to speak to the Teacher without interruption.						
	O	2. Child's statements are acknowledged with a verbal response or a physical gesture.						
	O	3. Teacher acknowledges child's feelings with an accepting, non-critical response or physical gesture (such as "I know you are sad that mommy is leaving" or "I know it makes you angry when she takes your toy").						
		C. Teacher positively manages children's behavior.						
	O	1. Teacher verbally intervenes to stop undesirable behavior — or undesirable behavior does not occur.						
	O	2. Consequences for undesirable behavior are briefly stated without critical tone —or it is not necessary to state consequences.						
	O	3. Consequences are implemented with consistency — or it is not necessary to implement consequences.						
	O	4. Undesirable behavior is redirected to desirable behavior — or undesirable behavior is not observed.						
	O	5. Teacher refrains from negative verbalizations (such as yelling, criticizing, scolding, threatening, sarcasm).						
	O	6. Teacher encourages children to identify alternative solutions to social-emotional conflict.						
		D. Children appear to be happy and involved in activities.						
	O	1. Children are smiling and laughing freely.						
	O	2. Children are cooperating and sharing.						
	O	3. Children are handling materials.						

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Clarification of Terms

Individualizing

A.1. A portfolio is an individual child's file folder that the teacher maintains and must include all of the following: child work samples, a performance inventory that summarizes the abilities of the child, descriptive notations of teacher observations of child behavior and/or progress.

A.2. Entries refer to child work samples, performance inventories, and/or teacher notations. At least one of these entries must be current within the past week. Score this item based on those materials contained in the child portfolio. If no child portfolio is available, score this item "No."

A.3. A developmental assessment is a narrative progress report or a performance inventory/checklist with comparisons made relative to the child's own performance. The developmental assessments must occur with a minimum of four (4) months between them.

B.1. System refers to a method of organizing a summary of classroom information about curriculum content and individual ability level of children. All areas of development (cognitive, language, social, and physical) must be included in the system. This item is concerned only with the *availability* of a written system of organizing information about skill development of abilities across the children in the class.

B.2. This item focuses on the *use* of the assessment system. It is most likely that such summaries would represent a teacher's working system for organizing and matching activities and children.

B.3. Grouping refers to gathering together a set of children for the purpose of a specific learning activity. Grouping is intended to be flexible, changing composition based upon the match between skill level or ability and a specific learning activity. The emphasis in this item is on the purposeful match in grouping children and matching of activity and ability. Accurate scoring for this item will require asking the teacher to describe how the summarizing system is used. If no classroom summary system is available or used, score this item "No."

B.4. The focus of this item is on the *application* of the classroom summary system in activity planning. Specific activities (which may be reflected in lesson plans) should correspond to abilities of the children in the class. It may be necessary for the teacher to describe the match or correspondence between the summary system and activities.

B.5. Opportunity to evaluate refers to the children's own perspective and analysis of their work efforts and products versus the teacher's verbal evaluation (i.e. "that's beautiful") or written evaluation (i.e. smiling face, check mark, number or letter grade on the child's paper). For example, the children are invited to compare their work products, to select their best and explain why it is viewed as their best.

C. Special needs are any special considerations that a child may have and may be developmental, physical, emotional, medical, social, etc. Special needs may be permanent conditions, such as diabetes, or temporary, such as a broken leg.

C.1. Procedure refers to the series of actions a teacher initiates when concerned that a child in the class may have a special need. For example, the teacher may request a conference with parents and determine next steps, document the concern on a report form, request an observation or evaluation of the child, etc.

C.2. Written description refers to any written documentation that provides information about the special considerations a child may require. This documentation may be provided by parents, administrator, resource personnel, etc. If the teacher indicates that there is not currently a child with special needs enrolled in the class, ask the teacher if previously there have been children with special needs and, if so, whether written information was provided.

D.1. Included in ongoing activities refers to the involvement of a child with special needs in all activities.

D.2. Modified refers to any adaptation in the procedures, and materials, or physical setting of an activity that may be necessary to accommodate children with special requirements.

D.3. Adequate provisions refers to physical accommodations made in classroom arrangement and furnishings to provide for physical special needs (such as wide pathways for a walker or leg braces, higher table or desk for wheel chairs, etc.).

Individualizing

OSPRI	Methods	Standards & Criteria	OBSERVATIONS 1		2		3	
			Yes	No	Yes	No	Yes	No
		A. Child assessment occurs systematically.						
	D	1. A portfolio is available for each child which includes child work samples, performance inventory, anecdotal/narrative reports.						
	D,R	2. Child portfolios contain entries that are current within one week.						
	D,R	3. A minimum of two developmental assessments for each child are completed annually.						
		B. Child assessment is used for planning individualized learning experiences.						
	D	1. A comprehensive system for summarizing children's abilities is available and includes all developmental areas: cognitive, language, social, physical.						
	D	2. A system is used to summarize the level of abilities and interests for the class.						
	D,R	3. Information from the system is used for grouping children by need.						
	D,R	4. Information from the system is used for planning specific activities.						
	O,D,R	5. Children have opportunities to evaluate their own work and the Teacher accepts child's self-assessment.						
		C. Teacher has a system for identifying special needs.						
	R	1. Teacher has a procedure for seeking advice and referrals for children suspected of having special needs.						
	D,R	2. Teacher receives written description of a child's specific, special needs.						
		D. Teacher is able to make provisions in the classroom for children with special needs.						
	O	1. All children are included in ongoing activities of the group.						
	O	2. Activities are modified to allow successful participation of all children.						
	O	3. Adequate provisions for space and equipment have been made to accommodate the physical abilities of all children.						

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Clarification of Terms

Individualizing

E.1. The focus of this item is on the communication between Parent and Teacher when a child with special needs is enrolled in the class and receiving services or treatment for these needs (such as speech therapy, eye or hearing exams).

E.2. Calendar refers to the teacher's planning calendar. The projected schedule refers to weeks and/or months that the teacher has plans for parent conferences. Parent conferences are individual meetings with the parents, or guardians, of each child in the class.

E.3. The focus of this item is on the teacher planning to conduct parent conferences at least two times during the year, typically in the fall and spring.

E.4. Notes refers to the teacher's written notations regarding information shared from teacher/parent conferences. These notations may refer to new information regarding the child, concerns discussed, or decisions made, etc.

E.5. Parent initiated communication may be either written or verbal.

Individualizing

OSPRI	Methods	Standards & Criteria	OBSERVATIONS					
			1		2		3	
			Yes	No	Yes	No	Yes	No
	R	**E. Conferences with individual parents are regularly planned.** 1. Teacher discusses progress and status of the child's special needs with parents at least once a month — or child with special needs is not currently enrolled.						
	D,R	2. Teacher keeps a calender with projected schedule of parent conferences.						
	D,R	3. Individual parent conferences are scheduled at least 2 or more times during the year.						
	D	4. Notes from individual parent conferences regarding their child's developmental progress and classroom experiences are available.						
	R	5. Teacher responds to parent initiated communication within 2 days.						

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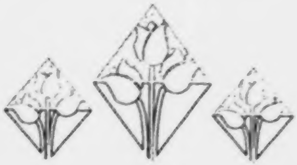

Benefits and Drawbacks of Early Childhood Inclusion

Benefits & Drawbacks of Early Childhood Inclusion

(adapted from Bailey and Winton, 1987)

Frank Porter Graham Child Development Center
The University of North Carolina at Chapel Hill

Early childhood inclusion refers to the practice of serving young children with special needs and typically developing children in the same child care or preschool classroom. Listed inside are some of the benefits and drawbacks of early childhood inclusion reported by parents of preschoolers with and without special needs. Circle the number that indicates the degree to which YOU feel each item represents a benefit or drawback of early childhood inclusion BASED ON YOUR OWN EXPERIENCES AND/OR BELIEFS. Please use the space provided on the back cover to describe additional benefits or drawbacks of early childhood inclusion.

Print your 6-digit ID Number here (first name and last name initials plus the last four digits of your social security number): ___ ___ - ___ ___ ___ ___ Today's Date: _______________

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Circle the number that indicates the degree to which YOU feel each item represents a benefit of early childhood inclusion BASED ON YOUR OWN EXPERIENCES AND/OR BELIEFS

Benefits of Early Childhood Inclusion	Definitely Not a Benefit	Probably Not a Benefit	Not Sure	Probably a Benefit	Definitely a Benefit
FOR CHILDREN WITH SPECIAL NEEDS					
1. Are better prepared for the real world	1	2	3	4	5
2. Develop more independence in self-help skills	1	2	3	4	5
3. Learn more from typically developing children	1	2	3	4	5
4. Are more likely to try harder	1	2	3	4	5
5. Are more likely to feel better about themselves	1	2	3	4	5
6. Have more opportunities to participate in a variety of activities	1	2	3	4	5
7. Are more likely to be accepted by the community	1	2	3	4	5
FOR FAMILIES OF CHILDREN WITH SPECIAL NEEDS					
8. Learn more about typical child development	1	2	3	4	5
Have more opportunities to meet and talk with families of typically developing children	1	2	3	4	5
FOR TYPICALLY DEVELOPING CHILDREN					
10. Are better prepared for the real world	1	2	3	4	5
11. Learn more about differences in the way people grow and develop	1	2	3	4	5
12. Are more aware and accepting of their own strengths and weaknesses.	1	2	3	4	5
FOR FAMILIES OF TYPICALLY DEVELOPING CHILDREN					
13. Are more understanding of families who have a child with special needs	1	2	3	4	5
14. Are more understanding of children with special needs.	1	2	3	4	5

Of the benefits listed above, which one is likely to be the greatest benefit of early childhood inclusion? Write the item number. ☐

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①

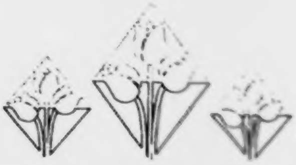
VERSION: 8/29/94

Circle the number that indicates the degree to which YOU feel each item represents a drawback of early childhood inclusion BASED ON YOUR OWN EXPERIENCES AND/OR BELIEFS

Drawbacks of Early Childhood Inclusion	Definitely Not a Drawback	Probably Not a Drawback	Not Sure	Probably a Drawback	Definitely a Drawback
▨ **FOR CHILDREN WITH SPECIAL NEEDS**					
1. Are less likely to receive special help and individualized instruction	1	2	3	4	5
2. Are less likely to receive special services, such as physical or speech therapy	1	2	3	4	5
3. Are more likely to be rejected or left out by teachers	1	2	3	4	5
4. Are more likely to be rejected or left out by other children	1	2	3	4	5
5. Are more likely to have teachers with little or no specialized training	1	2	3	4	5
▨ **FOR FAMILIES OF CHILDREN WITH SPECIAL NEEDS**					
6. May feel left out or ignored by families of typically developing children	1	2	3	4	5
7. May feel that most of the other families do not share or understand their concerns	1	2	3	4	5
8. Are more likely to notice and feel upset by differences between typically developing children and the child with special needs	1	2	3	4	5
9. May observe their child being rejected or teased	1	2	3	4	5
▨ **FOR TYPICALLY DEVELOPING CHILDREN**					
10. May not receive enough teacher attention	1	2	3	4	5
11. May copy negative behaviors of children with special needs	1	2	3	4	5
12. Do not receive their fair share of materials and equipment	1	2	3	4	5
▨ **FOR FAMILIES OF TYPICALLY DEVELOPING CHILDREN**					
13. Feel uncomfortable around children with special needs	1	2	3	4	5
14. Feel uncomfortable around families of children with special needs	1	2	3	4	5

Of the drawbacks listed above, which one is likely to be the greatest drawback of early childhood inclusion? Write the item number. ☐

VERSION: 6/29/94



Benefits and Drawbacks of Early Childhood Inclusion, Revised and Adapted

BENEFITS AND DRAWBACKS-REVISED

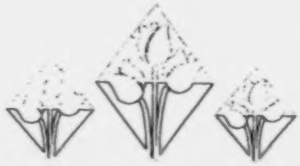
ID#______________________
DATE:______________________
CENTER:______________________

Circle the number that indicates the degree to which YOU feel each item represents the negative influence of early childhood inclusion
Based on your own experiences and beliefs

BECAUSE OF EARLY CHILDHOOD INCLUSION…

	…CHILDREN WITH SPECIAL NEEDS ARE:	**Strongly Agree**	**Agree**	**Undecided**	**Disagree**	**Strongly Disagree**
1.	Less likely to receive special help and individualized instruction	5	4	3	2	1
2.	Less likely to receive special services, such as physical or speech therapy	5	4	3	2	1
3.	More likely to be rejected or left out by teachers	5	4	3	2	1
4.	More likely to be rejected or left out by other children	5	4	3	2	1
5.	More likely to have teachers with little or no specialized training	5	4	3	2	1
	…FAMILIES OF CHILDREN WITH SPECIAL NEEDS:					
6.	May feel left out or ignored by families of typically developing children	5	4	3	2	1
7.	May feel that most of the other families do not share or understand their concerns	5	4	3	2	1
8.	Are more likely to notice and feel upset by differences between typically developing children and the child with special needs	5	4	3	2	1
9.	May observe their child being rejected or teased	5	4	3	2	1
	…TYPICALLY DEVELOPING CHILDREN:					
10.	May not receive enough teacher attention	5	4	3	2	1
11.	May copy negative behaviors of children with special needs	5	4	3	2	1
12.	Do not receive their fair share of materials and equipment	5	4	3	2	1
	…FAMILIES OF TYPICALLY DEVELOPING CHILDREN:					
13.	Feel uncomfortable around children with special needs	5	4	3	2	1
14.	Feel uncomfortable around families of children with special needs	5	4	3	2	1

Of these 14 items, which is most likely to be the greatest drawback of early childhood inclusion? Write the item number. ☐



Family Involvement Survey

Grade Level____________________

ID Number____________________

Date____________________

FAMILY INVOLVEMENT SURVEY

1. We would first like to obtain some general information about you and the early childhood program in which you work. Please fill in the answer to each of the following questions.

   a) Which of the following categories best describe the majority of families using your program? (Check ALL that apply)

      ____ working parents

      ____ single parents

      ____ teenage parents

      ____ extended families

      ____ foster families

      ____ stay-at-home mothers who want their children to attend preschool

      ____ Other____________________
      (please specify)

   b) How would you describe the majority of families using your program? (Check one choice)

      ____ African-American

      ____ Asian/Pacific Islander

      ____ White/Caucasian

      ____ American/Alaskan Indian

      ____ Hispanic

      ____ Other____________________

   c) What is the approximate family income of the majority of children in your program? (Check one choice)

      ____ $10,000 or below

      ____ $10,000 to $20,000

      ____ $20,000 to $30,000

      ____ $30,000 to $40,000

      ____ Above $40,000

      ____ Variety (alot of different income levels)

2. There are many different ways to involve families in early childhood programs. A number of these are listed on the next page. We would like to know whether you think each type of family involvement activity should be provided by your early childhood program. Please circle one choice for each:

SHOULD NOT DO	**means your program does not do this now and start. should not start.**
SHOULD START	**means your program does not do this now but should start.**
COULD DO BETTER	**means your program does this now but could do it better.**
DO WELL	**means your program already does this well.**

a)	Give parents information about their child's daily activities at the school.	**SHOULD NOT DO**	**SHOULD START**	**COULD DO BETTER**	**DO WELL**
b)	Obtain information from parents about the things that they and their child	**SHOULD NOT DO**	**SHOULD START**	**COULD DO BETTER**	**DO WELL**
c)	Obtain information from parents about family events that affect their child.	**SHOULD NOT DO**	**SHOULD START**	**COULD DO BETTER**	**DO WELL**
d)	Obtain information from parents about the goals they have for their child.	**SHOULD NOT DO**	**SHOULD START**	**COULD DO BETTER**	**DO WELL**
e)	Make personal contacts like phone calls to stay in closer touch with each child's family.	**SHOULD NOT DO**	**SHOULD START**	**COULD DO BETTER**	**DO WELL**
f)	Make home visits to get to know each child's family better.	**SHOULD NOT DO**	**SHOULD START**	**COULD DO BETTER**	**DO WELL**
g)	Conduct activities like workshops to help parents learn more about	**SHOULD NOT DO**	**SHOULD START**	**COULD DO BETTER**	**DO WELL**
h)	Provide instruction to parents about specific ways to help their children learn at home.	**SHOULD NOT DO**	**SHOULD START**	**COULD DO BETTER**	**DO WELL**
i)	Provide educational toys for parents to borrow to use with their children at home.	**SHOULD NOT DO**	**SHOULD START**	**COULD DO BETTER**	**DO WELL**
j)	Recruit parent volunteers to help at the school.	**SHOULD NOT DO**	**SHOULD START**	**COULD DO BETTER**	**DO WELL**
k)	Encourage drop-in visits by parents just to observe and visit at the school.	**SHOULD NOT DO**	**SHOULD START**	**COULD DO BETTER**	**DO WELL**
l)	Provide an area at the school where parents can just sit and talk with other parents.	**SHOULD NOT DO**	**SHOULD START**	**COULD DO BETTER**	**DO WELL**
m)	Provide an area at the school where parents can use parent education materials.	**SHOULD NOT DO**	**SHOULD START**	**COULD DO BETTER**	**DO WELL**

n)	Assist parents in locating needed services for their children, such as health care or recreational activities.	SHOULD NOT DO	SHOULD START	COULD DO BETTER	DO WELL
o)	Assist parents in locating needed family services, such as housing assistance or after-hours child care.	SHOULD NOT DO	SHOULD START	COULD DO BETTER	DO WELL
p)	Assist parents in locating services they might need for themselves, such as job training or other adult support services.	SHOULD NOT DO	SHOULD START	COULD DO BETTER	DO WELL
q)	Sponsor peer discussion or support groups for parents.	SHOULD NOT DO	SHOULD START	COULD DO BETTER	DO WELL
r)	Sponsor informal evening or weekend social activities for children and their families.	SHOULD NOT DO	SHOULD START	COULD DO BETTER	DO WELL
s)	Ask parents how your program could serve their family needs better.	SHOULD NOT DO	SHOULD START	COULD DO BETTER	DO WELL
t)	Involve parents in making decisions about things that go on in your program.	SHOULD NOT DO	SHOULD START	COULD DO BETTER	DO WELL

3. The beliefs that teachers have about families are important, but are often overlooked in planning early childhood programs. We would value your judgments on the following questions. Please circle one choice for each statement. Base your answers on your most common experience. We know that there will be exceptions to this general answer.
Remember --- ALL of your answers are anonymous.

YES means you AGREE STRONGLY.

yes means you AGREE A LITTLE.

no means you DISAGREE A LITTLE.

NO means you DISAGREE STRONGLY.

a)	The parents using our school understand appropriate ways to raise their children.	YES	yes	no	NO
b)	When children come to the school with behavior problems, it reflects badly on their parents.	YES	yes	no	NO
c)	We can count on parents to follow through on requests from our school.	YES	yes	no	NO
d)	All parents can become better parents if they receive the support they need.	YES	yes	no	NO
e)	It is best for parents to be independent and not to rely on others for help.	YES	yes	no	NO

f)	Parents are quick to find fault with things they don't like about our program without noticing the good things that we do.	YES	yes	no	NO
g)	Parents should expect the school to do things to help them as adults in addition to providing good educational programs for their children.	YES	yes	no	NO
h)	The parents using our program really try to do a good job of parenting.	YES	yes	no	NO

4. Until now, the questions have mainly asked for your thoughts about your early childhood program and the families who use the program. We would also like to know how you feel about your own work as a teacher or caregiver. Please circle one choice for each of the following questions. Again, base your answers on your most common experience.

ME means this is VERY TRUE FOR YOU.

me means this is SORT OF TRUE FOR YOU.

not me means this is NOT VERY TRUE FOR YOU.

NOT ME means this is NOT AT ALL TRUE FOR YOU.

---

a)	I usually enjoy working with the parents of the children in my school.	ME	me	not me	NOT ME
b)	Getting to know and working with parents is an important part of my job responsibility.	ME	me	not me	NOT ME
c)	I am comfortable talking to parents about problems their children are having at the school.	ME	me	not me	NOT ME
d)	I need more training in how to get parents involved in what goes on at our school.	ME	me	not me	NOT ME
e)	I find that working with parents brings me more problems than pleasures.	ME	me	not me	NOT ME
f)	When I make plans for the year, I set goals for my work with parents as well as for my work with children.	ME	me	not me	NOT ME
g)	I feel confident giving parents advice about their children's development.	ME	me	not me	NOT ME

5. Whose needs are given the highest priority in your early childhood program? (Check one choice)

____ Children ____ Parents ____ Balance between Children & Parents

6. If you would like, please use this space to tell us more things about working with families based upon your own feelings and experiences.

1-414-229-4725 x3728

This survey was adapted with permission from Christine Burton, Ph.D., School of Education, University of Milwaukee - Wisconsin Enders Hall, P. O. Box 413, Milwaukee, Wisconsin 53201.

Self-Assessment for Child Care Professionals

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Print your 6-digit ID Number here (first name and last name initials plus the last four digits of your social security number): ____ ____ ____ ____ ____ ____ Today's Date: ____________

Self-assessment for child care professionals

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The University of North Carolina at Chapel Hill

DATE COMPLETED: ___/___/___

Directions: Listed below are skills needed to care for and teach young children, ages birth through five years. For each item, circle a number to show how knowledgable and skilled you are(*Column 1*) and then indicate your need for additional training(*Column 2*).

	Column 1					*Column 2*				
	How knowledgable and skilled are you in each of the following areas? *Circle only one number for each item:*					How much additional training do you feel you need? *Circle only one number for each item:*				
CHILD DEVELOPMENT	little knowledge and skill		some knowledge and skill		much knowledge and skill	little training needed		some training needed		much training needed
1. Help children learn and develop in the following areas:										
(a) language (how they communicate)	1	2	3	4	5	1	2	3	4	5
(b) cognitive/intellectual (how they think and solve problems)	1	2	3	4	5	1	2	3	4	5
(c) emotional/social (how they feel about themselves and relate to others)	1	2	3	4	5	1	2	3	4	5
(d) behavior (how they control their actions)	1	2	3	4	5	1	2	3	4	5
(e) fine motor (how they use their small muscles to handle objects)	1	2	3	4	5	1	2	3	4	5
(f) gross motor (how they use their large muscles to run and play)	1	2	3	4	5	1	2	3	4	5
2. Know what things increase a child's chances of having special needs and can recognize early warning signs that a child may be slow or need help	1	2	3	4	5	1	2	3	4	5
3. Know about the growth and development of:	1	2	3	4	5	1	2	3	4	5
(a) infants	1	2	3	4	5	1	2	3	4	5
(b) toddlers	1	2	[illegible]	4	5	1	2	3	4	5
(c) 3-4 y[illegible]ds	1	2	[illegible]	4	5	1	2	3	4	5

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CHILD CARE ENVIRONMENT	**Column 1** How knowledgable and skilled are you in each of the following areas? *Circle only one number for each item:* little knowledge and skill		some knowledge and skill		much knowledge and skill	**Column 2** How much additional training do you feel you need? *Circle only one number for each item:* little training needed		some training needed		much training needed
Set up and maintain an environment (classroom) that:										
(a) is healthy and safe	1	2	3	4	5	1	2	3	4	5
(b) is flexible and takes into account the children's likes and dislikes	1	2	3	4	5	1	2	3	4	5
(c) promotes language	1	2	3	4	5	1	2	3	4	5
(d) reflects the children's cultures and other cultures	1	2	3	4	5	1	2	3	4	5
(e) promotes independence	1	2	3	4	5	1	2	3	4	5
(f) promotes playing with others	1	2	3	4	5	1	2	3	4	5
(g) can be supervised easily	1	2	3	4	5	1	2	3	4	5
Make changes in the space, materials, or activities so all children can participate, including children with special needs	1	2	3	4	5	1	2	3	4	5
Provide spaces for the children to be alone, to gather in small groups, and to play all together	1	2	3	4	5	1	2	3	4	5
Set up areas for activities such as art, blocks, books, sand, water, music, manipulatives, dramatic play, and active play	1	2	3	4	5	1	2	3	4	5

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	Column 1					Column 2				
	How knowledgable and skilled are you in each of the following areas?					How much additional training do you feel you need?				
	Circle only one number for each item:					*Circle only one number for each item:*				
CURRICULUM AND LEARNING	little knowledge and skill		some knowledge and skill		much knowledge and skill	little training needed		some training needed		much training needed
8. Know what to do if I think a child has special needs	1	2	3	4	5	1	2	3	4	5
9. Work together with families and others to:										
(a) get to know the children well, including their strengths and needs	1	2	3	4	5	1	2	3	4	5
(b) plan how best to meet the children's needs	1	2	3	4	5	1	2	3	4	5
(c) evaluate how the children are doing	1	2	3	4	5	1	2	3	4	5
10. Guide childrens' behavior and deal with situations in a way that helps them solve their own problems and learn self-control	1	2	3	4	5	1	2	3	4	5
11. Change the way I teach to meet the special learning needs of the children	1	2	3	4	5	1	2	3	4	5
12. Set up activities ahead of time and give children plenty of notice before it is time to change activities	1	2	3	4	5	1	2	3	4	5
13. Provide many opportunities for the children to make choices	1	2	3	4	5	1	2	3	4	5
14. Use play as one way of teaching and build in many opportunities for play throughout the day	1	2	3	4	5	1	2	3	4	5
15. Use different ways to encourage children, including those with special needs, to talk to and play with each other	1	2	3	4	5	1	2	3	4	5
16. Work closely with families and other adults to plan c[illegible]n's moves to new classrooms or progra[illegible]	1	2	[illegible]	4	5	1	2	3	4	5

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PROFESSIONALISM	How knowledgable and skilled are you in each of the following areas? Circle only one number for each item: little knowledge and skill	some knowledge and skill			much knowledge and skill	How much additional training do you feel you need? Circle only one number for each item: little training needed	some training needed			much training needed
7. Know about local, regional, and state resources for children who have special needs and their families	1	2	3	4	5	1	2	3	4	5
18. Understand what state and federal laws say about children with special needs and their families	1	2	3	4	5	1	2	3	4	5
9. Protect each family's right to privacy and confidentiality	1	2	3	4	5	1	2	3	4	5
0. Communicate with families often and offer many different ways for them to be a part of their children's program, such as serving on boards, visiting in the classroom, and attending parent meetings	1	2	3	4	5	1	2	3	4	5
1. Communicate clearly and take care of disagreements among adults in a professional way	1	2	3	4	5	1	2	3	4	5
2. Know and talk to other child care providers in the community as a way of growing and learning in my profession	1	2	3	4	5	1	2	3	4	5

3. From items 1-22, list your top three choices for additional training. Enter the number (and letter if there is one) in the spaces provided: first choice, second choice, third choice.

First choice for training ☐ Second choice for training ☐ Third choice for training ☐

4. What areas of training do you need that are not listed in the items above?

5. What training have you received that has helped yo t the needs of young children with disabi ?

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Self-Assessment

Module 1 Handout 2

Directions: Write "T" on the line before each statement that is true.
Write "F" on the line before each statement that is false.

____ 1. A developmentally appropriate environment meets the individual needs of all children in that environment.

____ 2. Child care personnel may need to work with other professionals to care for and teach children with disabilities.

____ 3. Children with and without disabilities play together as friends without adult guidance.

____ 4. Mainstreaming means that all children with disabilities will be in the same child care settings as nondisabled children without appropriate support and training for child care providers.

____ 5. Working with parents is an important part of a developmentally appropriate child care program.

____ 6. Children with mental handicaps do not have the ability to be in child care settings with typical children.

____ 7. Most children take their first step by the time they are six months old.

____ 8. It is acceptable to say, "That cerebral palsy girl is learning to walk."

____ 9. If a two-year-old boy in your child care setting center seems to be slow learning to talk, you should wait at least six months before referring him to a specialist. Waiting will give him time to outgrow his language delay.

____ 10. When parents of children with disabilities mainstream their child, they may be concerned that their child will be teased by other children.

____ 11. In a developmentally appropriate program, three year olds are expected to sit quietly at tables for most of the day.

____ 12. Mainstreaming may help nondisabled children be more accepting of other children who are different.

____ 13. All twenty-four month old children should be toilet-trained.

____ 14. Children with spina bifida are children who have difficulty seeing things that are far away.

____ 15. A positive attitude toward mainstreaming and a willingness to try something different are keys to including children with disabilities in child care settings.

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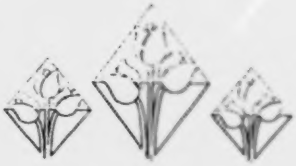


Teacher Rating Scale of Social Interaction

Figure 3.1

Teacher Rating of Social Interaction

Child's Name: ____________________

Rater's Name: ____________________

Date: ____________________

Social Interaction Rating Score _____

Instructions

Listed below are descriptive statements about children's social interaction. Please read each statement and decide how true or descriptive it is for the child's behavior during the past two weeks. Then circle the number which best indicates how true or descriptive the statement is for the child.

1. Child talks to other children while playing

Occurs very little		Occurs sometimes		Occurs often
1	2	3	4	5

2. Child shares toys with other children.

Occurs very little		Occurs sometimes		Occurs often
1	2	3	4	5

3. Child initiates play with another child

Occurs very little		Occurs sometimes		Occurs often
1	2	3	4	5

4. Child responds to initiations by another child.

Occurs very little		Occurs sometimes		Occurs often
1	2	3	4	5

Total Positive Score __________

(the sum of the numbers circled)

5. Child stands or sits alone, not engaged in play.

Occurs very little		Occurs sometimes		Occurs often
1	2	3	4	5

6. Child plays with toys inappropriately.

Occurs very little		Occurs sometimes		Occurs often
1	2	3	4	5

7. Child interacts negatively with other children.

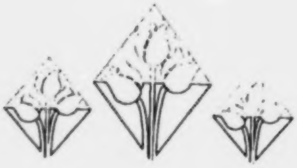
Occurs very little		Occurs sometimes		Occurs often
1	2	3	4	5

8. Child interacts mostly with adults.

Occurs very little		Occurs sometimes		Occurs often
1	2	3	4	5

Total Negative Score _______

(the sum of the numbers circled)



Developmental Observation Checklist System - DOCS

Developmental Observation Checklist System

A Systems Approach to Assessing Very Young Children

EXAMINER'S MANUAL

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Rationale and Overview of the DOCS

Research and federal legislation reflect an increased focus on the very young child, including parental input and environmental influence. The need to identify at-risk children at younger ages has been well established; however, few comprehensive screening measures are available. The *Developmental Observation Checklist System* (DOCS) was developed with these needs in mind. This chapter reviews:

1. Why the DOCS was developed
2. The rationale for early identification
3. An explanation of a systems approach
4. The DOCS model
5. The DOCS report format
6. The purposes of the DOCS

Why the DOCS Was Developed

Standardized screening and assessment of young children requires well-developed measures that have been designed to simultaneously address (a) the domains of normal development, (b) the need for parental input, and (c) the evaluation of intrapersonal and environmental influences. According to several sources (Coons et al., 1982; Meisels & Provence, 1989), measurement instruments for infants, toddlers, and young children should display several characteristics. In summary, early childhood assessment instruments should:

1. Allow easy and accurate parent and professional administration;
2. Be based on a large normative sample representative of children in the child's culture;
3. Foster comparison among similar aged children;
4. Clearly indicate the abilities and aptitudes being measured;
5. Be reliable and valid to the extent that appropriate children can be identified;
6. Be designed to be administered quickly;
7. Be designed for administration to large groups of children, thus facilitating referral to the appropriate source;
8. Use clear and concise language that can be easily understood by consumers;
9. Include a sufficient number of items at each age level, especially during the early years;
10. Use multiple information sources, including family members;
11. Be inexpensive, thus making recurrent screening and assessment during the first few years of life highly feasible.

The DOCS was designed with these considerations in mind. It is appropriate for use with infants from birth to children 6 years of age.

Rationale for Early Identification

The early identification of developmental delays in high-risk children has been of long-standing interest to professionals in the medical, allied health, and educational communities. Kopp and Krakow (1983) summarized several large-scale longitudinal research projects funded by the federal government such as the Collaborative Perinatal Project of the National Institute of Neurological Diseases and Blindness, Graham's study of anoxia, and the Kauai studies. During the 1960s, P.L. 90-248 supported screening children who were at risk for health or developmental problems. The works of J. McVicker Hunt (*Intelligence and Experience,* 1961) and Benjamin Bloom (*Stability and Change in Human Characteristics,* 1964) contributed a great deal to establishing the theoretical basis for early intervention. In the 1970s, P.L. 94-142 enhanced the educational opportunities of all children with handicaps from ages 3 to 21 by expanding the age range and services. Because P.L. 94-142 was considered a weak mandate for the 3- to 5-year-old population, it was amended in 1986 by P.L. 99-457, which strengthened and extended identification and intervention services down to birth. These mandates shifted the emphasis of personnel in mental health and human services from the school-age population to very young children. The publication *Fourteen Ounces of Prevention* (Price, Cowen, Lorion, & Ramos-McKay, 1988) provided elaborate evidence attesting to the efficacy of early intervention for at-risk and disabled populations.

Early identification of, and treatment for, developmental delay is beneficial to a child's subsequent skill and knowledge acquisition. Research suggests that early intervention ultimately leads to enhanced school performance. Further, studies verify the educational and social cost-effectiveness of early identification and intervention (Casto, White, & Taylor, 1983). After three decades of research and practice in early intervention had taken place, federal legislation mandated early intervention efforts through the Education of the Handicapped Amendments of 1986 (U.S. Public Law 99-457).

P.L. 99-457 and early intervention research stress the need for identifying children who have problems at the earliest possible age and for screening and assessment evaluation in cognitive, language, motor, social, self-help, and physical domains. Recently, research and legislative emphasis has been on family involvement in the evaluation process (where the parents serve as a part of the assessment team) as well as on environmental assessment (*Federal Register,* 1989; Fewell, 1991).

Thus, research and federal legislation mirror the current interest and concern of professionals that young children be identified for developmental delays in order to provide appropriate interventions. Although the need for early diagnosis and intervention is apparent, early childhood professionals are faced with a lack of psychometrically sound assessment instruments. As some authors acknowledged (Cicchetti & Wagner, 1990; Dunst & Trivette, 1990; Krauss & Jacobs, 1990), the new emphasis on early identification requires ". . . careful deployment of established assessment procedures, supplemented by newly developed techniques to provide highly discriminating methodologies . . ." (McCune, Kalmanson, Fleck, Glazewski, & Sillari, 1990, p. 219). The development of new measures must reflect the changing emphasis in early childhood intervention and assessment from a focus of evaluating the "intelligence" and "cognition" of children to a broader view focusing on the interrelatedness of systems and a move toward discipline-oriented assessment that also includes the family.

By using their own criteria to evaluate assessment instruments used with infants and young children, Katoff and Reuter (1980) found few technically appropriate tests. Most had technical problems, had poor validation and reliability, were overly simplistic measures, lacked sufficient items per age level, were incomplete assessments of all developmental domains, were socioeconomically biased, had lengthy administration time, or were expensive. Additionally, very few devices were developed for children below the age of 3 years. Of those tests available, most had only a few items per age level, oversimplifying the developmental complexity that is especially important during the first year of life when there is a highly accelerated rate of skill acquisition (McCall, 1983). So many significant problems existed in standard testing that in 1977, the federally based Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program agreed to accept clinical assessment of developmental status conducted by pediatricians in lieu of standardized measurements by early interventionists (Katoff & Reuter, 1980).

The concerns facing educators of young children in the 1980s continue to persist. Recent literature reviews indicate similar problems with current preschool-oriented assessment instruments (Campbell, 1991; Meisels, 1989). Greer, Bauchner, and Zuckerman (1989) reported that the original *Denver Developmental Screening Test,* one of the most popular screening devices in the United States, lacked sensitivity and failed to identify 80 percent of the children who subsequently demonstrated developmental or academic delay. This screening device has since been revised to remedy some of the identified weaknesses. However, in a recent article by Frankenburg, Dodds, Archer, Shapiro, and Bresnick (1992) they acknowledged that the *Denver Developmental Screening Test–Revised* continues to be normed using the population from a single state.

In a recent article Campbell (1991) stressed the need to track high-risk populations over time. The high cost of such projects, however, makes such a task prohibitive. Campbell noted the need for low-cost screening and assessment that meets the needs outlined in P.L. 99-457 of evaluating both child and family characteristics. Few screening and evaluation instruments are based on a multidimensional approach that integrates environmental characteristics, parent information, child adaptive behaviors, and developmental assessment. The need for a broader based assessment strategy, however, is stressed in P.L. 99-457 and reflected by several decades of research.

A Systems Orientation to Early Assessment

The theoretical basis for using a multidimensional assessment approach to young children, especially those below 3 years of age, was introduced in the early 1970s by Sameroff and Chandler (1975). Their view of development is based on the premise that the child does not develop in isolation but is affected by family dynamics. Recent research based on social systems theory (Dunst, Trivette, Hamby, & Pollock, 1990; McCubbin et al., 1980) has emphasized family characteristics such as stress and support in the family unit as critical factors when evaluating the young child. Play was also emphasized in the research literature beginning in the 1970s and was considered especially important during the first year of life (Bee et al:, 1982). Early play practices were found to form the basis for later developmental competence in cognition, language, and social skills. The child's ability to respond to environmental influences in an adaptive manner also influences development (Sameroff & Chandler).

The DOCS was developed to satisfy the established need for a quick, inexpensive, and well-normed screening device to identify potential developmental delay. It has a sufficient number of items, interactive play items at the earlier developmental levels, environmental input in the form of sections on family stress and support, as well as problematic child behaviors. Family involvement, as mandated by P.L. 99-457, is further emphasized by the parent-report nature of the DOCS questionnaire.

The DOCS Model

Assessment of young children has two purposes: prediction of ability at a later time and early identification of developmental delay or deviance. Whereas prediction tries to estimate future functioning from knowledge of present levels of competence, early identification seeks to determine the intervention needs required at the present time. Prediction is difficult because infant measures of competence are poor predictors of future ability in later academic status or school learning (McCune et al., 1990; Shonkoff, 1983). Early identification, however, focusing on both strengths and weaknesses, provides a valid approach for guidance in further assessment and in determining intervention strategies (Blackman, 1986).

Most approaches to understanding and assessing development in young children acknowledge the comprehensive and interrelated nature of young children's abilities and aptitudes. Thus, in developing the Developmental Checklist (DC) component of the DOCS, we chose to keep the individual domains of language, social, motor, and cognition, while stressing their overlapping relationship.

A second concern relates to the limitations of assessment procedures. Historically, quantitative approaches to early childhood assessment have focused on norm-referenced measures, ordinal scales, and curriculum-based assessments of the child's abilities. The limitations associated with quantitative measures are well known and recognized. We concur that quantitative measures have limitations and may not reflect all aspects of development. The alternative approach of qualitative measurement, however, also has limitations. We believe that the acceptance of one approach versus another fails to recognize the advantages of each approach. Using a quantitative approach as a first level gives the examiner preliminary data and allows the examiner to target abilities and aptitudes that may require more in-depth, qualitative analysis. This is similar to the approach taken by Salomon (1991). Bayley, writing in the manual for the *Bayley Scales of Infant Development* (1969), anticipated the limitations of quantitative assessment and potential controversies surrounding the use of norm-referenced, quantitative instruments with young children:

> . . . the primary value of the developmental indexes is that they provide the basis for establishing a child's current status, and thus the extent of any deviation from normal expectancy. (p. 4)
>
> . . . the examiner of exceptional children will probably wish to supplement the score, or age equivalent, with a careful qualitative study of the protocol in order to observe the particular areas of strength and weakness. (p. 34)

Building from the established research base, the DOCS frame of reference supports a multidimensional assessment paradigm. This approach, essentially a social systems implementation, includes a broad perspective, considering not only the developmental skills of the infant or child, but also the environmental milieu, family dynamics, and intrapersonal adaptability. This approach is in line with both current theory and the guidelines of P.L. 99-457. The seminal work by Sameroff and Chandler (1975) has been the foundation for including the child, parent, and environment as integral parts of the screening process. Therefore, numerous items were included that involve the report of play interactions between the child and parent. Subsequent research by McCubbin and his colleagues (1980) and extensive research by Dunst and his associates (1990) supported the decision to add a section on

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stress and support as well as two subscales measuring influences that might affect normal skill acquisition.

The DOCS contains three components that provide a multifaceted screening and assessment system. The DOCS components are (a) Part 1: Developmental Checklist (DC), (b) Part 2: Adjustment Behavior Checklist (ABC), and (c) Part 3: Parental Stress and Support Checklist (PSSC). The Developmental Checklist is a parent-report questionnaire that assesses normal development in the areas of cognition, language, social, and motor domains. The Parental Stress and Support Checklist identifies family stress regarding the child and support used to mediate the stressors. The Adjustment Behavior Checklist screens for any problematic behaviors in the child's ability to adapt to his or her environment. Table 1.1 contains a schematic of the DOCS components.

Consistent with legislation as listed in the *Federal Register* (1989) for children aged birth to 6-0, the developmental domains chosen for the DOCS include cognition, language, social, fine motor skills, gross motor skills, and adaptive functioning in the environment. Based on reviews by Katoff and Reuter (1980) and guidelines for screening and assessment by Meisels and Provence (1989), a large number of items were chosen for each developmental domain in the DC, especially from birth to 3 years of age, where reviewers found other screening devices to have limited numbers of items. Items were chosen to ascribe to the concepts of representativeness, continuity, and relatedness as described by Cicchetti and Wagner (1990). Representativeness refers to the degree to which the items measure the construct in question. Continuity refers to stability over time. Relatedness refers to the construct having some degree of psychological importance that defines its relevance in determining development.

Numerous experts in the field of early childhood intervention have attested to the interrelated nature of developmental skills, which is especially true in the first 3 years of life (Bee et al., 1982; Dunst, 1985; Handley & Spencer, 1986). Therefore, in the DC, each of the developmental domains are assessed separately as well as combined into a composite developmental score. Further, an individual strength–weakness profile is generated. The developmental areas of cognition, language, social, and motor are listed on the profile in Table 1.1, which reflects a hierarchy of normally developing skills in each domain screened by the DC. The ABC and the PSSC were included in the DOCS because current theory suggests that delays in development do not occur in isolation but rather represent a complex dialectic involving innate capacities and external influences (Krauss & Jacobs, 1990).

> The vast majority of the disorders of the early years of life can best be characterized as such transactional "relational pathologies" and not as disorders arising solely "within the child" (cf. Greenspan & Porges, 1984; Sroufe & Fleeson, 1986). . . . Specifically, assessment must attend to all domains of development and to the nature of the parent–child–environment system. (Cicchetti & Wagner, 1990, p. 253)

The ABC screens for any problematic behaviors in the child's ability to adapt to his or her environment. The PSSC screens the family stress and support impacting on the child's developmental progress. The PSSC items were developed with three broad family dimensions as described by Moos and Moos (1981). These dimensions included relationship dimensions indicating the degree of family cohesion or conflict, personal growth dimensions indicating the value placed on achievement and moral aspects of family life, and system maintenance dimen-

TABLE 1.1
DOCS Components

Area Measured	DC				PSSC	ABC
	Language	Social	Motor	Cognition		
Language	X	X		X		
Social Ability		X				X
Parental Stress					X	
Parental Support					X	
Fine/Gross Motor			X			
Child Adaptability		X			X	X
Cognitive	X	X		X		
Overall Development	X	X	X	X		
Play	X	X		X		
Parent–Child Interaction	X	X		X	X	
Environmental Impact		X		X	X	X

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sions including the family's organizational and control structures.

The DOCS Report Format

The DOCS uses adult report, ideally the parent, as the medium for administration for each component of the screening instrument. The individual should be able to base her or his responses on observation of the child's daily behaviors. "Careful observation of children's abilities as they occur naturally and interviews with caregivers are key to making contact with a young child's understanding of the work" (Paget, 1990, p. 107). The parent-report format of the DOCS allows large numbers of infants and children to be identified at a minimal cost because there is no need for a highly trained professional to administer the screening instrument. A parental questionnaire eliminates the need for expensive and unwieldy stimulation objects so often used in screening and assessment. Meisels (1991) suggested that parents are keen and reliable observers of their children's behavior, especially at early ages where children often do not perform well for strangers. This assumption that parents are adequate reporters is supported by Miller, Manhal, and Lee (1991) and Rossetti (1986). Squires and Bricker (1991) reported that even poorly educated young mothers of low socioeconomic status rated their infants in a questionnaire with the same accuracy as professionals utilizing a standardized assessment instrument. Further, using the parents as an information source leads to a therapeutic alliance between parents and those providing intervention. "A therapeutic alliance between parents and service providers is a prerequisite for any successful intervention" (Parker & Zuckerman, 1990, p. 359).

Primary caregivers other than the parents, such as day care or preschool personnel, may also complete the DC when appropriate. These persons may use the DOCS for screening large numbers of children once they have observed the child for a long enough period of time to respond adequately to questions about how the child performs in each of the developmental areas assessed. Thus they are able to document the need for further assessment prior to formal referral.

The Purposes of the DOCS

The DOCS has the following seven purposes:

1. To identify both those infants and children who are developing normally and those significantly below their peers in acquiring cognitive, language, social, and motor abilities and who may be candidates for additional assessment or intervention
2. To identify those infants and children whose adjustment behavior may indicate that they are at risk for developmental problems and are candidates for additional assessment
3. To identify those family concerns such as stress and lack of support that may impact on the infant's or child's development
4. To more accurately determine the specific professional to whom referral may be made and to aid in directing further diagnostic assessment
5. To serve as a measurement device in research studies pertaining to early identification of, and intervention with, high-risk populations
6. To give direction to instructional practice
7. To document educational progress

Each of these purposes is discussed here.

Identifying Infants and Children with Developmental Delays or Deficits

A major reason for identifying infants and children with developmental delays or deficits at very young ages is to facilitate early intervention. Infants and children who display subtle impairment are especially difficult to identify with current screening devices. Several decades of research and practice find that early intervention is effective and even cost efficient (Casto et al., 1983). Federal mandates now focus on the most effective methods of implementing early intervention efforts (*Federal Register*, 1989). The DC component of the DOCS proposes to meet this challenge by using sufficient developmental items at each age based on systems theory, with attention to parental involvement. Though the parent is viewed as a primary informant on the DC questionnaire, teachers or other interventionists who have worked with the child a sufficient length of time can provide a second, equally sensitive information source.

Assessing Adjustment Behavior

Every child has behavior problems from time to time. Many behaviors are appropriate at one age but indicate problems during another age. For example, bed-wetting is normal for many 2 year olds but may indicate a problem after the age of 3. Behavior adjustment problems can cause familial stress and may have a negative impact on

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the child's developmental skills, social interaction, or preschool experience (Beckman, 1983; Bristol, 1987). The ABC component of the DOCS can identify these difficulties, substantiate that a problem exists, and assist referral to the appropriate professional at the earliest opportunity.

Determining Levels of Familial Stress and Support

Research studies have reported increased stress levels in families of at-risk and exceptional children. Familial stress in the absence of support systems used to mediate the stressors may have a negative impact on the child's developmental skill acquisition. Low stress levels or stress in the presence of adequate and appropriate support systems positively influences developmental outcome (Dunst & Trivette, 1986). The Parental Stress and Support Checklist (PSSC) component of the DOCS includes information on aspects of family functioning that will assist the professional in choosing the direction that intervention should take.

Facilitating Referral by Determining Strengths and Weaknesses

A screening device that provides a strength–weakness profile in all areas of development in addition to providing for family input facilitates more accurate referrals to the appropriate professional (Fewell, 1991). Thus, weaknesses in the areas of cognition, social, or maladaptive behavior would prompt a referral to a professional skilled in the area of mental health or early intervention for further evaluation. A language delay would indicate a referral to a speech/language pathologist for additional assessment. Educators receiving screening information could specifically direct assessment in the area of weakness. Use of a parent-report questionnaire assures that the screening will be less time-and-labor intensive, which results in lower cost, thus increasing the number of children who can be screened and referred. As previously noted, Campbell (1991) advocated a screening instrument that is a well-normed, inexpensive method geared to both family and child characteristics. The specific design of the DOCS will allow for large-scale, yet comprehensive, screening of infants and young children.

Research

A great deal of research has been amassed over the last 50 years regarding early identification of high-risk populations. Several reviews indicate that many of the available screening devices do not meet the need for evaluation of infants and young children in a multidimensional approach that includes developmental skill information in the context of environment and family. In addition, these existing devices reflect weaknesses in reliability, validity, and number of items in the birth to 3-0 age range. Because of instrument weakness, much of the foregoing research has been of limited value. With the publication of the DOCS, researchers will have a stronger and more complete screening device that can be useful in identifying high-risk infants and children with potential developmental delay. Thus, research with these populations will be of additional value and promote further investigation in the area of early identification of developmental delays.

Giving Direction to Instructional Practice

As indicated earlier, every item on the DC component of the DOCS was theoretically related to at least one of the broad, overlapping aspects of development as noted in Table 1.1. Although performance on individual DC items should not be used as the basis for curriculum development and intervention, perusal of the items can provide information that is of clinical value. "The pattern of items that are passed and failed allows an analysis of skill development that can form the basis of an intervention plan" (McCune et al., 1990, p. 220). The adept clinician or interventionist can use each item diagnostically to help direct additional evaluation or diagnostic teaching efforts and to determine beginning intervention. When interventions are planned, we agree with the National Association for the Education of Young Children that activities must be carefully selected in order that they be developmentally appropriate (Bredekamp, 1987). Instruction may take the form of parent training or a change in focus from the child to the parent to alleviate stress or to provide support (Dunst, 1985).

Documenting Educational Progress

The final purpose of the DC component of the DOCS is to provide clinicians, interventionists, early childhood educators, teachers, and psychologists with the means for anchoring a base from which to monitor change (Cicchetti & Wagner, 1990) and thus a beginning place for evaluating a student's progress in special early childhood settings. Once a student has been assessed and enrolled in a special program, those responsible for his or her education must monitor the success of the special instructional effort. This monitoring entails, in part, periodic retesting of students. In certain circumstances, laws or policies require documentation of student progress. This is particularly true for most experimental or demonstration projects funded by state or federal governments. Regardless, monitoring a student's progress is always desirable in terms of sharing information with parents and the students themselves. The information gained can also be used as evidence that a program should be continued, modified, or terminated. The DC component of the DOCS, with several types of standard scores (including NCE scores), is well suited to this purpose.

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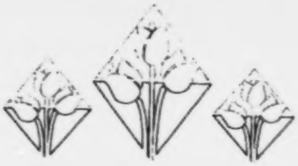

The Enterprise Zone-Preschool Inclusion Project

A Model for Inclusion:
A Quantitative Evaluation

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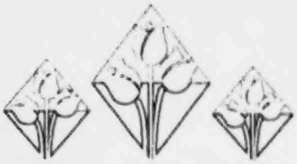

Enterprise Zone - Preschool Inclusion Project

Evaluation

A Model for Inclusion: A Quantitative Evaluation

NOTE

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A Model for Inclusion: An Evaluation

INTRODUCTION

Although great strides have been made during the last two decades towards including young children with disabilities within neighborhood child care centers designed primarily for children without disabilities, evaluations and reviews demonstrate mixed results regarding the efficacy of various inclusive programs (Klinger, Vaughn, Hughes, Schumm, Elbaum, 1998; Manset & Semmel, 1997; Marston, 1997; Waldron & McLeskey,1998). Specifically, inclusion is the practice of providing children with disabilities the opportunity to learn and interact with children without disabilities in a stimulating, natural environment, which encourages growth and development. Awareness and knowledge of inclusionary practices continues to expand as federal legislation engenders hopes of successful implementation in high quality child care environments. Numerous articles depict the benefits of inclusion for young children and their families (Baker, Wang, & Walberg, 1995;Chandler, 1994; Chang & Teramoto, 1987; Heller, Manning, Pavur, & Wagner, 1998; Parsons & McIntosh, 1988; Wolery & Wilbers, 1994). An inclusionary environment increases the probability of empathy and compassion on the part of children, increases the likelihood of later acceptance of children with disabilities by normally developing peers, and leads to a mind set that integration is the norm (Buysse & Bailey, 1993). Thus, children with disabilities who attend inclusive child care centers are able to feel a sense of belonging to their community, and children and child care providers learn to appreciate the diversity of the human family, as societal values of equality are modeled (Favazza & Odom, 1997; Guralnick, Connor, Hammond, Gottman, & Kinnish, 1996; Raschke & Bronson, 1999).

Since 1975, federal law has stated that all children ages 5 to 21 with disabilities have the assurance of a free appropriate public education (FAPE) in the least restrictive environment (LRE). The reauthorization of the Individuals with Disabilities Act (IDEA, 1997), first signed in 1986 as P.L. 99-457, strengthens academic expectations and accountability for the nation's 5.8 million children with disabilities and bridges the gap that has too often existed between what children with disabilities learn and what is required in a regular curriculum. Furthermore, Part C of IDEA 1997, requires that States implement policies and procedures that guarantee "to the maximum extent appropriate, early intervention services are provided in natural environments, and the provision of early intervention services for any infant or toddler occurs in a setting other than a natural environment only if early intervention cannot be achieved satisfactorily for the infant or toddler in a natural environment" (34 CFR Part 303.167(c)). The legal rationale for inclusionary practices has been strengthened by the expansive Americans with Disabilities Act (ADA), which protects people with disabilities from discriminatory practices. Recently, both IDEA and ADA have come under attack by groups eager to dilute their respective authority. In addition to the legal debate, the fundamental goal of inclusion continues to elicit controversy and concerns among the general public. For example, many parents express concern that inclusion could harm the development of their children (Bricker, 1995). Although research has demonstrated that this type of fear is unfounded, numerous concerns remain (Hanline & Daley, 1999; Staub & Peck, 1994).

A significant concern is that many teachers still hold misconceptions about inclusion, and lack the training and knowledge to facilitate successful inclusionary programs. Teachers often feel that they are not trained or equipped to meet the special needs of children with disabilities and their families. For instance, many teachers have not been formally instructed on the social, emotional, cognitive, and physical issues related to children with disabilities. As a result, these teachers are not sure how to implement effective inclusionary practices within their classrooms. Still other teachers are fearful that inclusionary classrooms will increase their workload and hinder their overall effectiveness (Gellens, 1996; Scruggs & Mastropeiri, 1996).

In addition to teachers' concerns, parents of children with disabilities often express fear that their children will not be given the same attention as the typical children (Guralnick, 1994). Likewise, parents of normally developing children may fear that their children will receive less time and attention due to the demands that children with disabilities place on the teacher. These are all valid concerns and reflect the complexity of the human rights issues involving children with disabilities.

It is generally accepted that in order for inclusion to be effective, classroom teachers and parents must be receptive to the demands, and be educated to meet the diverse needs of children with disabilities (Gold, Liepeck, Scott, & Benjamin-Wise, 1999). Research has demonstrated that at best, inclusionary environments enhance the developmental growth of children with disabilities, and at worst, special education classes offer no advantages over normal classroom for most children with disabilities (Wert, Caldwell & Wolery, 1996; Biklen & Zollers, 1996). Moreover, including children with disabilities in regular classrooms may help normally developing children to garner a greater appreciation for individual differences (Buysee & Bailey, 1993). Furthermore, according to Hanline (1985), typically developing children are more apt to model behaviors of other nondisabled children than a developmentally delayed child. She suggests that even if a nondisabled child imitates a child with disabilities, it will be the appropriate behavior, rather than the inappropriate behavior.

In order to achieve the full benefits of inclusion, providing in service training for child care providers is necessary but not sufficient (Gold et al., 1999). Gold advocates a systemic approach to inclusion, incorporating mentoring and Special Instruction Consultants (SICs) along with a comprehensive training curriculum to enhance the success of inclusionary classrooms (Gold et al., 1999).

The purpose of this evaluation is to assess the impact of the implementation of our model for inclusion. The results of this study will be used to support the ongoing viability of The Enterprise Zone-Preschool Inclusion Project (EZ-PIP) and to make program modifications. This evaluation is multidimensional, including considerations of cost-effectiveness, equity, quality, satisfaction, and sustainability.

Our Model for Inclusion

The Enterprise Zone-Preschool Inclusion Project (EZ-PIP), conducted at the Mailman Center for Child Development, began in 1997 and was designed to expand, implement, evaluate, and disseminate a model inclusionary program that would increase quality child care services for all children. Previous research conducted at our center found instructional based methods, that taught early care and education providers about the issues and concerns of children with disabilities to be limited in scope (Gold et al, 1999). Although providers found knowledge about inclusion to be helpful, they had a difficult time implementing what they had learned. For example, a teacher who underwent training could readily identify the students who required evaluation for a possible disability. However, she was still unsure about what she could do to improve the educational experience for these children while they were waiting for their evaluation. As a result of these and similar concerns, EZ-PIP was developed with three major components: 1) Training for child care providers, 2) Providing a Special Instruction Consultant as a field resource, and 3) Adding a teacher mentoring program where colleagues could seek out each other for advice, support, and guidance (see Figure 1). Thus, it was our intention to provide child care providers with the instruction and support needed in order to improve the quality of care provided to all children, with particular attention to those with disabilities.

Education and Awareness Training

The first part of our project was to develop and deliver inclusion training to child care providers in our community. The objective of the training was to increase the knowledge of inclusionary practices, increase awareness of issues related to inclusion, and help providers recognize children in need of referrals for evaluation. Eleven, two hour training sessions were developed (see Figure 2). Each session was informal and filled with activities, videos, and reading materials to maximize the learning experience for the participants. Training was offered during nap time and money was provided to centers to pay for substitutes so participants could attend. Attendance at each session was required to earn a certificate of completion, which fulfilled our state's requirement of eight hours of in-service training each year for child care providers. Since training occurred during the school year over several months, child care providers were able to apply knowledge gained in training directly to their environment. If questions or concerns arose between training sessions, participants were encouraged to bring these up for group discussion at future meetings. As a result, providers not only gained knowledge and awareness of inclusionary practices, they also received information for improving the overall quality of their center for all children. The following excerpt from a letter we received from a child care provider who attended our training program illustrates the positive effect training can have:

> *I have been a child caregiver for the past five years. I love working with children. Recently I met a child who has muscular dystrophy who started to attend our center. When I first saw him, I didn't know how to*

react. Having him enter the classroom made me feel uncomfortable at first because I was not sure how his disability would affect the class. I hoped that I would be able to do the right thing. As it happened, the other children teased him at first because they did not understand why he could not walk like them. So, I taught the class about muscular dystrophy, explaining the physical effects it has on a person, while emphasizing that a person with a disability is no different than them. In the following weeks, the children asked questions about the disability and accepted our new student as one of their own, offering assistance and inviting him to play with them.

In the last year, I have taken your classes to help me deal with events like the one I just mentioned. If I did not take any of these classes, I believe I could not have handled this situation properly. These classes have helped me overcome the fear of being around a person with a disability. In particular, the classes have taught me how to act and what to do, to make everyone comfortable when a person with a disability enters the center. Working with a child who has a special need is different because it depends on the severity of the disability, however, I believe that any dreams are possible if you have a little help along the way.

From the above we hear how this child care provider applied what was learned in training and was able to create a comfortable learning environment for the entire center. Perhaps more importantly, this provider was able to gain confidence in her abilities, which allowed her to feel comfortable working with children with disabilities. If further support had been needed, our model provides two additional field resources: the Special Instruction Consultant (SIC) and a peer mentorship program.

Special Instruction Consultant

The SICs are individuals who have training in inclusionary practices in addition to formal special education courses. Our model was adapted from Florida's Department of Health for children 0 to 3 years of age and adjusted for use with children ages 3 to 5. SICs supplied the child care providers with instructional techniques, professional advice, assistance with refining their daily schedules, and ideas to redesign their classroom environment. Providers could utilize the SICs' services whenever the need arose, all they needed to do was request a SIC to visit their class. A notebook was developed for each center, which contained important information to guide the teachers through the identification and evaluation process for children with possible disabilities. Action plans were then designed for children who were in the evaluation process. These plans included all pertinent information on progress, services, and diagnosis, when available, as well as recommendations from the SI consultant. The teachers would then use this information to work with each child.

Without the services provided through training and the SIC, many children with disabilities may have gone undiagnosed. This is demonstrated by the fact that prior to the EZ-PIP project, there were no children with diagnosed disabilities enrolled in the twelve child care programs in our first cohort of trainees. Although no policy changes related to admitting children with disabilities were made, 21 centers that never accepted or identified children with disabilities are now serving them. Due to EZ-PIP, at those 21 centers, 126 children with disabilities are now being served. Some of the disabilities identified among the children served include autistic spectrum disorder, pervasive developmental disorder, speech language disorder, developmental delay, and attention deficit hyperactivity disorder. The following vignette highlights the services provided from the perspective of the SIC:

> *A child care provider recently contacted me because she was concerned about a child in her class. She explained that she noticed that the child was having difficulty communicating with the center staff and her peers. On her own, the provider applied what she learned in training to screen the child for social, motor, cognitive, and language development. She found evidence of a possible problem with the child's ability to distinguish sounds. At this time she contacted me to find out where to send the child for further evaluation. I went to the center, conducted a classroom observation, and provided the necessary referral information to the child's family and the child care center staff. As a result, the child was sent to a speech/language pathologist and was diagnosed as having a hearing impairment. She is now receiving services that she requires and is able to participate actively in her classroom.*

Thus, the SIC is able to provide a service to the child care centers that allows the children, teachers, administrators, and families to work toward best inclusionary practices. In addition to the knowledge gained through training, the SIC can be utilized to complement and expand the provider's competency. Indeed, the mere availability of the SIC can serve to reduce fears that providers may have about working with children with disabilities.

Mentoring

Another component of our model is peer mentoring. Educating the child care providers is important, however, it does not ensure the continued success of inclusionary classrooms. Having an experienced child care educator available as a *mentor* can provide the support needed for providers to implement the information obtained through training (Odell, 1990). One of the most important functions of mentors is to help providers identify their strengths and personal skills. As such, mentors empathize and communicate genuine feelings of acceptance, translate the art and science of teaching, and apply models of assistance according to the needs of the teachers (Head, Reiman, & Thies-Sprinthall, 1992). Indeed, truly effective mentoring is a very complex process for both mentor and protégé.

Mentors participating in our model were required to complete the EZ-PIP classroom training along with eight hours of inclusionary instruction adapted from the National Center for The Early Childhood Work Force (Whitebook, Hnatiuk, and Bellm, 1994).The mentors were child care providers working in the field, who were familiar with the cultural and special concerns related to their community. The mentors were provided with a "mentor's" notebook that contained the training curriculum for the EZ-PIP inclusion course, activity handouts, community resource contact numbers, and techniques and methods for professional development and classroom management. The next vignette, from one of our mentors, provides an example of how this program works:

> *Being a child care provider myself I am familiar with the day to day concerns my colleagues face at the preschools. As a mentor I share my experience and specialized knowledge about inclusion for those who request advice, support, or resource information. For instance, a provider contacted me because she was not sure how to improve the learning experience for a child who had a disability. The child would become upset easily when he could not perform a task as quickly as his peers. Sometimes he would misbehave or become disruptive. After meeting with the provider, we worked together and came up with a behavior management plan. We decided upon several behavioral management techniques, where the child would receive individualized attention from both the providers and peers. With a little extra time and attention, the child's behavior improved and the learning process was enhanced. At the same time the provider gained a greater understanding of behavioral management techniques, while I increased my competencies in order to better help other providers in need.*

Evaluation Questions

The questions guiding the evaluation model can be characterized in two groups: quantitative and qualitative. Quantitative questions were primarily addressed with the use of research based standardized instruments. Qualitative questions were addressed by conducting 6 separate focus groups with participating administrators and teachers (see separate qualitative analysis later in this section). The four guiding questions that were addressed as part of the overall evaluation were:

1. Is there a significant impact in overall general development in children with and without disabilities as a result of implementation of the model?
2. Is there a significant impact on teachers' classroom environment as a result of implementation of the model?

3. Is there a significant impact on teachers' knowledge about appropriate educational practices as a result of implementation of the model?

4. Do teachers and administrators find the model to be effective and feasible in serving children with disabilities?

METHODS

Design

A quasi-experimental pretest-posttest design was used to answer the quantitative research questions. This evaluation focuses on the assessment of the direct effects of the EZ-PIP program, and corresponds with our program objectives.

Sample and Procedures

The project was implemented in three different geographical areas in Miami-Dade County, FL. A total of 41 child care centers evenly distributed among these three areas opted to participate in the project. Participation in the project entailed a one-year commitment to partake in teacher and administrator training sessions, participation in children's data collection (i.e., Developmental Observation Checklist System), participation in activities involving mentoring other teachers, and participation in focus groups at the end of the year to provide feedback on the project. A total of 183 teachers and 27 administrators were enrolled in the project throughout the five years of project implementation. Table 1 describes participants by year of the project.

Table 1. Description of EZ-PIP participants by year of the project

	YEAR 1	YEAR 2	YEAR 3	TOTAL
Child Care Centers	18	9	14	41
Teachers	75	42	66	183
Administrators	8	11	8	27

The three types of intervention, *Education and Awareness Training Special Instruction Consultants (SIC)* and *Mentoring* are described in the previous section.

Instruments

The Assessment Profile for Early Childhood Programs: Research Version (Abbott-Shimm & Sibley, 1998) is an 87 item classroom observation checklist, designed for use as a research measure, used to provide quantitative measures of classroom and teaching practices that facilitate the learning and development of children in early childhood care facilities. The items, scored "Yes" or "No", are organized into five Scales; Learning Environment, Scheduling, Curriculum, Interacting, and Individualizing. The latter two represent procedures and behaviors that exemplify standards for classroom practices. Both Cronbach's alpha and the Spearman-Brown corrected split-halves reliability coefficients were adequate across the five dimensions of the Profile. The following alpha's were given: Learning Environment .87, Scheduling .79, Curriculum .87, Interacting .98, and Individualizing .97. The following Spearman-Brown corrected reliability coefficients were given: Learning Environment .92, Scheduling .81, Curriculum .97, Interacting .99, Individualizing .98.

The Developmental Observation Checklist System (DOCS); Hresko, Miquel, Sherbenou, & Burton, 1994) is a screening device for identifying younger children with potential developmental delays. The DOCS includes three components, a Developmental Checklist (DC), an Adjustment Behavior Checklist (ABC), and a Parent Stress and Support Checklist (PSSC). The two components of the DOCS that were utilized in the current study included the DC in order to measure the general development of young children, and the ABC to assess adjustment behaviors. The DC includes 475 items for which the caregiver provides a "yes" or "no" answer to descriptions of specific behaviors to measure current skills in Cognitive, Language, Social, Motor, and Overall development. The ABC consists of 25 descriptions of negative behaviors of children, using a 4-point scoring system (from very much like to not at all like). The DOCS manual translates the raw scores into percentiles, standard scores, normal curve equivalent (NCE) scores, and age equivalents. The DOCS was standardized throughout 30 states between the years 1939 to 1992, the norm group consisted of 1,094 individuals reflecting a close approximation to the general population in terms of ethnicity, gender, urban-rural status, and geographic location. The internal consistency, using coefficient alpha, is .99 for the DC subtests and overall score across most age groups (range is .94-.99). The internal consistency for the ABC varies from .81 to .90. Test-retest reliabilities ranged from .85 to .96 for three separate age groups on all components of the DC, and on the ABC (14 to 21 days between administrations). Interrater reliability on a single sample of 30 children ages 4 to 5 comparing parent and caregiver scores on the DC, is greater than .90 for the subtests as well as the total score. Concurrent validity was examined through numerous studies using sample sizes ranging from 20 to 35 for age groups of 3 to 4 years and older. Correlations between the total scale score for the DC and comparable scales were high: for example, .72 with the McCarthy Scale, .74 with Denver-R, and .71 with the Slosson Intelligence Test (Revised). The ABC was highly correlated with the Test of Early Socioemotional Development and the Vineland Adaptive Behavior Scale (r = .65 and .69, respectively). Construct validity evidence is provided by comparison of scores with chronological age and the statistical significant intercorrelations of the sections of the DC with the ABC and PSSC.

Ethical Considerations

Some of the instruments originally considered for the evaluation activities of EZ-PIP were eliminated at different points of the study. The primary reasons these instruments were removed are two-fold. First, many of the statistical properties of the instruments (i.e., reliability coefficients) were lost when using the measures with non-English speaking samples, thus weakening the results. Also, some measures were initially pilot tested and their wording (described by participants as "too confusing") resulted in invalid results as some of the participants left many items unanswered (e.g., Benefits & Drawbacks). As a result a fully quantitative evaluation became a mixed quantitative-qualitative evaluation. It was the opinion of the evaluation team that by adopting a mixed model, the data collected would gain in statistical properties as well as in depth.

One other issue that might have impacted the quantitative evaluation of the project is related to the administration of the DOCS. Teachers were trained in the administration of these instruments and data collection was conducted primarily by participant teachers. Even though this practice might have weakened the strength of the data collected (by introducing a strong confounder), it allowed the Primary Investigator to reach one of the main objectives of the demonstration project, i.e., education and training of early childhood primary caregivers. By receiving training on the DOCS administration teachers also received training in child development basics as well as in classroom observation skills and interventions for children with special needs. In other words, even though some consistency of results might have been weakened, one important gain was teacher training in observational skills, early identification of children with disabilities and early intervention for children with special needs.

Given some of these modifications, the reader is invited to apply caution when interpreting the results of the DOCS.

RESULTS

Prior to discussing the results pertinent to the main predictions of this study, the mean, standard deviations and t-scores among independent variables (IV's) are presented. The sample consisted of classrooms from multiple preschools throughout Miami Dade and the individual students attending those specific classrooms. Table 2 presents the means, standard deviations and t-scores of The Assessment Profile for Early Childhood Programs (Profile) Learning Environment, Scheduling, Curriculum, Interacting, and Individualizing scales (n=39 classrooms). Table 3 shows the means, standard deviations and t-scores for two components of The Developmental Observation Checklist System (DOCS): The Developmental Checklist (DC) Cognitive, Language, Social, Motor, Overall Development scales (n=216 students) and the Adjustment Behavior Checklist (ABC) Negative Behaviors scale (n=180 students).

TABLE 2

Pre and Post Test Differences for Classroom's Receiving EZ-PIP Training

	Group				
	Pre-Classrooms (n=39)		Post-Classrooms (n=39)		
Variable	M	SD	M	SD	t (38)
Profile					
1. Learning Environment	46.65	9.98	53.38	8.22	-3.783*
2. Scheduling	57.11	3.71	56.83	5.70	.265
3. Curriculum	42.45	3.85	47.96	8.20	-4.110*
4. Interacting	48.67	5.38	50.52	7.14	-1.344
5. Individualizing	44.69	10.50	46.91	10.20	-.883

*p ≤ .001.

TABLE 3

Pre and Post Test Differences for Student's Enrolled in the Classrooms Receiving EZ-PIP Training

	Group									
	Pre-Students (n=216)		*Post-Students (n=216)*		*Pre-Students (n=180)*		*Post-Students (n=180)*			
Variable	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*df*	*t*
DOCS (DC)										
1. Cognitive	91.74	10.99	92.70	9.34					215	-.958
2. Language	94.22	10.51	96.24	11.57					215	-1.81*
3. Social	98.50	11.56	99.58	11.88					215	-.93
4. Motor	95.50	11.41	97.29	12.74					215	-1.50
5. Overall Development	94.53	9.99	95.41	10.81					215	-.82
DOCS (ABC)										
1. Negative Behaviors	111.38	21.13	107.29	19.98					179	-1.86*

*p < .05.

DISCUSSION

Preliminary quantitative results appear quite encouraging. First, on The Assessment Profile for Early Childhood Programs significant positive changes were observed in two important areas, a) Learning Environment and b) Curriculum. One hypotheses, later explored in focus groups, was that a significant part of the training allowed teachers to adjust their early childhood education practices to factors directly under their control (i.e., their classroom and the content of their lessons) thus, directly impacting their classroom and portions of the curriculum. Other factors such as Schedule and Interaction appeared as fixed factors in the sense that teachers reported less level of control over these. For instance, the former is related to established practices while the latter is related to underlying personality factors. In the same fashion, Individualized Education can be directly related to the student-teacher ratio, more stringent in programs such as Head Start while significantly more flexible in other early childhood education programs. In summary, in terms of classroom environment as measured by The Assessment Profile for Early Childhood Programs this project reflected significant impact on those variables that teachers seem to have more control over and less impact on those that would require more time or approval of the owner of center director.

In addition, results on the DOCS appear consistent, to a certain extent, with those obtained on the Assessment Profile for Early Childhood Programs. For instance, results indicate a statistically significant difference between pre and post measures of language development as well as a significant decrease in inappropriate or negative behaviors. Language development and behavior management were issues commonly reported as "matters of concern" by participant teachers. Some of the changes observed on these two variables could be due to bias on teachers' part, i.e., since these were issues that concerned them in particular they devoted more time and energy to interventions that addressed language and behavior. On the other hand, these variables are more sensitive to change (i.e., open to observation and measurement) than variables such as cognitive development or social behavior that can acquire different meanings in cross cultural settings. A word of warning in the interpretation of this data was already stressed, however, it is important to address a concurrent pattern with the previous instrument in respect to behavior. As a result of their participation in the project, teachers gained skills in behavior management that they were able to implement in the classroom setting. This application of acquired knowledge appeared to have a direct impact on the reduction of inappropriate or maladaptive behaviors that children exhibited prior to implementing the training sessions.

Limitations of the Project

Inclusion training, Special Instruction Consultants, and mentoring components comprise the main aspects of our demonstration model. We are continually assessing the efficacy of our model and strive to make necessary improvements. Nonetheless, several additional issues must receive attention before inclusion can become a reality in our community. For instance, systematic early identification of children with disabilities needs to be in place so that children are identified in a timely manner, thus reducing the time lapse between initial detection, later identification and implementation of services. Another factor to consider is related to teachers' education and training. It is obvious that dispensing education and training to early childhood educators has a direct impact on some of the variables of interest, i.e., classroom environment and child development. In the same fashion there is a significant need to move away from an archaic model of early childhood educators as mere "caretakers" to one more professionalized. Even though this is an idea reflected in many professional publications, our community seems to lack the will at the time of addressing this issue. As a result, early childhood educators continue to work long hours, receive low wages and receive insufficient education for the tasks they face on a daily basis. Finally, resources must be allocated by administrators to support those changes that can and have occurred in the classrooms as a result of implementation of the project. Changes in learning environment and curriculum will continue provided that early childhood program administrators give continuous support to their educational staff (Craig, Haggart, Gold & Hull, 2000). In other words, for classrooms to be inclusive and for children with disabilities to be part of these, a community effort involving all levels of decision-making is needed. Policy makers, administrators, early childhood teachers, higher education institutions, financial and educational resources must be coordinated so that changes in the classroom can occur. Although our project was not without limitations, it was sufficient to elucidate that changes can happen provided appropriate action is taken. Empowering educators with knowledge was a small step, yet a significant one.

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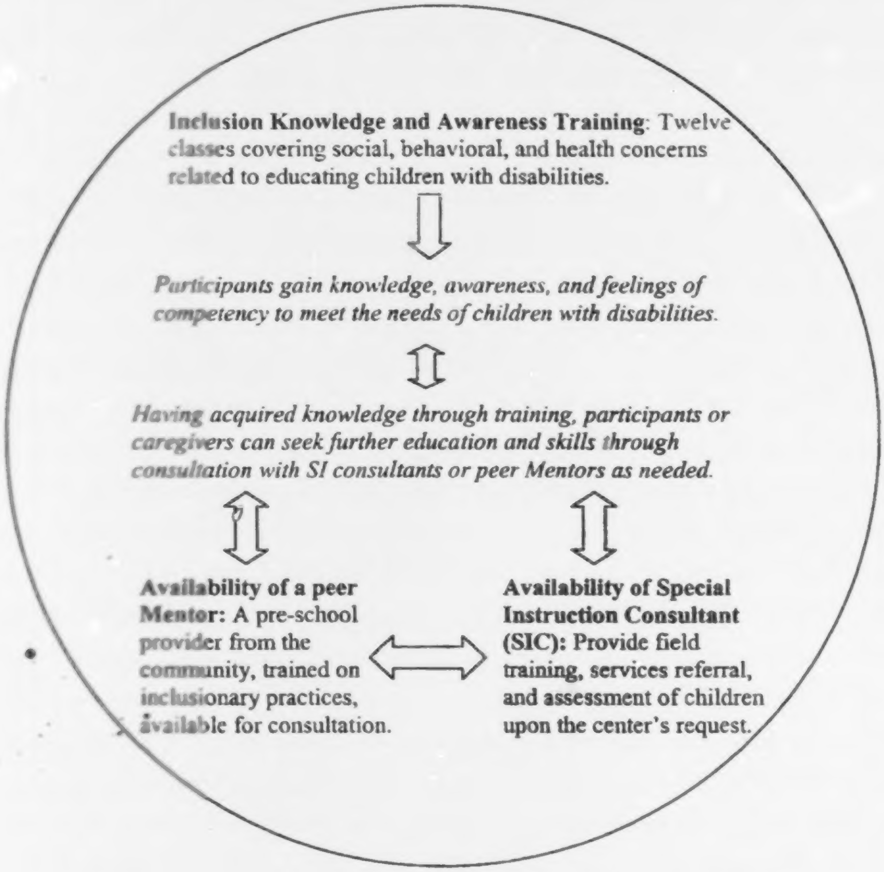
Figure 1: EZ-PIP Inclusion Training Model



Inclusion Knowledge and Awareness Training: Twelve classes covering social, behavioral, and health concerns related to educating children with disabilities.

Participants gain knowledge, awareness, and feelings of competency to meet the needs of children with disabilities.

Having acquired knowledge through training, participants or caregivers can seek further education and skills through consultation with SI consultants or peer Mentors as needed.

Availability of a peer Mentor: A pre-school provider from the community, trained on inclusionary practices, available for consultation.

Availability of Special Instruction Consultant (SIC): Provide field training, services referral, and assessment of children upon the center's request.

Figure 2: EZ-PIP Training Curriculum

Session I The Philosophy of Inclusion

- What is inclusion
- Inclusion does not work without training and support
- The benefits of inclusion
- The laws, PL 94-142, 99-457(IDEA) and ADA
- Understand your community partners
  Expectations of participants

Session II Early Brain Development Learning a Teacher Screening Instrument

- The effect the environment has on children
- The brain's development
- The impact of traumatic stress, neglect or abuse on young children
- The impact of early childhood providers on young children

Session III Screening Young Children in the Classroom Setting

- What is screening
- What is assessment
- Child development
- Inclusive child care settings and developmentally appropriate practices

Session IV The Child Who Seems Different: Meeting Special Needs

- What are developmental disabilities
- Risk factors that may contribute to developing a disability

Session V Developmentally Appropriate Practices and Adapting the Classroom

- Developmentally appropriate practices and the importance of DAP
- Children learn through play
- Child/Adult interactions in the classrooms
- Scheduling and routines
- Classroom structure and materials
- Accommodating children with disabilities in the classrooms
- Adapting the curriculum

Session VI Behavior Management

- Encouraging positive and managing negative behaviors
- Types of, and reasons for behavior problems
- Strategies

Session VII Intellectual Development: What You Can Do To Help

- Overview of normal development
- Developmental disabilities and retardation
- Teaching techniques and general guidelines

Session VIII Speech and Language Development

- Communication mechanisms
- Speech, sound and sentence development
- Conditions that effect speech and language development
- Indications for speech/language difficulties
- Screening tools for teachers

Session IX Health Care: Infection Control, Medication Administration and Seizure Management

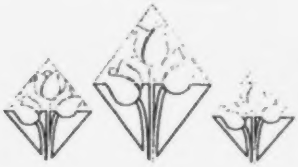
- Fears when dealing with children's health impairments
- Confidentiality
- Procedures for health and safety

Session X Working Together: Communication and Teamwork in the Caregiving Setting

- Attitudes: respect for individual differences and dignity of children
- Peer tutoring and peer interaction
- Work as a teaching team to serve children with disabilities
- Needed instructional support and materials
- Work with the parents of children, assistant teacher, and administrators

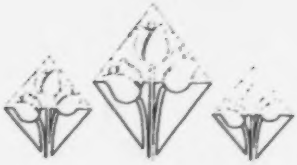
Session XI Professionalism and Advocacy

- Consult administration with any concerns
- Discuss professional organizations
- Promote participation in community activities and child advocacy
- Video-ABC's of inclusion
- Summary of training sessions



The Enterprise Zone-Preschool Inclusion Project

A Model for Inclusion:
A Qualitative Evaluation



Enterprise Zone – Preschool Inclusion Project Evaluation

A Model for Inclusion: A Qualitative Evaluation

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Executive Summary

Four semi-standardized focus groups were conducted to explore the perceptions, attitudes and beliefs of those who participated or continue to participate in the Enterprise Zone - Preschool Inclusion Project (EZ-PIP) demonstration project. Specifically, the focus groups sought attitudes and beliefs pertaining to the inclusion of children with disabilities in preschool and investigated the effectiveness of EZ-PIP. This document reports the findings of those focus groups particularly regarding perspectives on 1) models of inclusion, 2) effectiveness of training, 3) effectiveness of mentor model, 4) effectiveness of SICs, and 5) accreditation. In addition to these, serendipitous findings relevant to program efficacy were explored.

Text data from transcripts were entered into a qualitative data analysis software tool where they were fractured and re-organized through coding. In the analysis, 12 multi-perspective themes emerged. Those themes constitute the findings, and are briefly described here.

Children with Disabilities, Socialization, and Social Construction of Disability—Participants shared perspectives on children with disabilities. Most shared the notion that students with disabilities required additional attention, which some perceived as unfair to other students. In some cases, center personnel described the effects social environment has on children's socio-emotional and behavioral well-being. In addition, participants identified with a view that including children with disabilities in their regular classrooms was an effective means of increasing social and academic skills of all students. Center personnel also described meanings of disability, including that disabilities are socially-constructed and, thus, not real. In addition, center personnel said they did not like labels.

Educating Children with Disabilities—When asked to describe the best ways to educate children with disabilities, several participants simply said, "Like you would teach anyone else." Teachers and administrators provided ideas on working with and educating children with disabilities. While they provided different interpretations of its meaning, most said that providing accommodations was important. Another recurring provision was to engage parents and, for some participants, working with parents was the first and most essential task. A point of difference was whether to include students with special educational needs in the same classroom as other children or to place them separately.

Making Inclusion Work—Participants provided a short list of factors that improve inclusion models at their centers. These included educating other children to accept students with special needs, staff buy-in to the practice of inclusion, having a staff that is sensitive and adequately trained, and sufficient planning time.

Parent Involvement—Participants recognized parent involvement as a key to the success of their center's program. They also, however, described parents as barriers. The concerns were that parents do not participate, some are not receptive to requests for participation, and they do not follow center policy. Some participants were concerned about how parents are not consistent in their treatment of their children, which, in turn, affects behavior in class. In addition, center personnel saw it as their duty to inform and educate parents about education, disabilities, and center procedures.

Need for Training and Who Should Receive it—Participants suggested improving the program by increasing the amount of training and enhancing its quality. Administrators shared criteria they use for selecting whom they send to training: staff "buy-in," the need for sensitivity about students, possessing an interest in working with students, being professionally prepared, and, in the case of the training provided, the ability to speak English. Another issue was the amount of coverage administrators were able to provide their centers. The limitations of sending only selected personnel become an issue when considering employee turnover.

Effect of Mailman/EZ-PIP Training—Participants made several comments about the training they were provided. Overall, they indicated an interest in the training and an appreciation for it, but saw room for improvement. These included comments about the ways training was provided and recommendations for improving the training, follow up, time and place for holding the training, and the perceived effect of the sessions.

Special Instruction Consultant—SICs encouraged and motivated teachers, especially in learning about inclusion. In addition, SICs were described as helpful, readily available, responsive, and providers of good information. At the same time, however, center personnel shared a handful of concerns about the consistency of services, the roles of SICs, effectiveness, and the amount of time SICs spent at each center.

Mentor Model—Participants shared their enthusiasm about having access to a mentor. Some reported acquiring useful information from mentors. Most participants, however, were critical of the mentoring they received. Specific concerns included: 1) lack of mentor follow though, 2) poor planning, 3) inconsistent visits, 4) mentor turnover, 5) short amount of time spent on-site, 6) low levels of comfort and rapport, 7 sense of little efficacy, and 8) obscure roles. Lack of mentor follow though, poor planning, inconsistent visits, mentor turnover, short amount of time spent on-site, low levels of comfort and rapport, sense of little efficacy, obscure roles.

Accreditation—While the specifics varied, most participants felt that accreditation helps to raise standards while, simultaneously, brings hardships to centers. Participants thought accreditation would be more meaningful if it were universal. In the administrator focus groups, this belief was followed by a discussion about the ways accreditation is a factor in improving the quality of education, as well as some of the negative aspects of accreditation.

This is not a comprehensive evaluation. Findings are based on participants' perspectives on ways to improve EZ-PIP. Specific recommendations are made in the Recommendations and Discussion Section of this report.

Purpose and Objectives

Purpose—Four semi-standardized focus groups were conducted to explore the perceptions, attitudes and beliefs of those who participated or continue to participate in the Enterprise Zone - Preschool Inclusion Project (EZ-PIP) demonstration project. Specifically, the focus groups sought attitudes and beliefs pertaining to the inclusion of children with disabilities in preschool and investigated the effectiveness of EZ-PIP. The data obtained through the different groups was intended to be integrated into the data analyzed using various measurement instruments. Issues explored, which were based on a meeting for EZ-PIP, and sample questions included:

1) **Models of inclusion**: Dialogue covered description of children with disabilities and label, early childhood teaching practices and notions of inclusion; What do you think of children with disabilities? What do you see as a good educational model to educate children with disabilities?

2) **Effectiveness of training**: Discussion covered the need for training, which teachers should participate in training, its effectiveness, and ideas on improving the training. What do you see as the best model to receive education on children with disabilities? What did you like the most about the training? What did you like the least about training? How do you think training sessions could have been improved? What do you think could have been done to improve workshop attendance?

3) **Effectiveness of SIC and mentor models**: Discussion about the strengths and weaknesses of the SIC and mentor models; Did you use the mentor/s available? Did you find them useful? What are the positive aspects of the mentor model? What are the negative aspects?

4) **Effectiveness of training/mentor model**: Dialogue about the effectiveness of the EZ-PIP training. What aspects of the model would you change? How would you improve it in order to maximize the model's effect (i.e., to reach a larger number of children)? If you were asked for a model to promote inclusion in early childhood that includes active participation of parents and teachers, how would you do it?

5) **Accreditation**: Discussion about the strengths and limitations accompanied with accreditation. What is the importance of accreditation?

6) **Revisiting, revising, and creating ideas:** Prompts for teachers and administrators to revise their ideas and to share their own agenda items with the focus group.

A goal of this exploratory study was to discover professionals' perspectives and input on making effective the inclusion of children with disabilities in preschool. Moderators looked to the participants as "experts" who could provide their insight on planning and implementing effective inclusion practices and specific ways to improve the EZ-PIP program.

Program Description

Inclusion—A consistent body of literature illustrates the benefits of inclusion for young children and their families (Baker, Wang, & Walberg, 1995; Chandler, 1994; Chang & Teramoto, 1987; Heller, Manning, Pavur, & Wagner, 1998; Parsons & McIntosh, 1988; Wolery & Wilbers, 1994). An inclusionary environment increases the probability of empathy and compassion on the part of children, increases the likelihood of later acceptance of children with disabilities by normally developing peers, and leads to a mind set that integration is the norm (Buysse & Bailey, 1993). Children with disabilities who attend inclusive child care centers are able to feel a sense of belonging to their community, and children and child care providers learn to appreciate the diversity of the human family, as societal values of equality are modeled (Favazza & Odom, 1997; Guralnick, Connor, Hammond, Gottman, & Kinnish, 1996; Rashke & Bronson, 1999). Teachers often feel that they are not trained or equipped to meet the special needs of children with disabilities and their families (Eiserman, Shisler, & Healey, 1995; Scrugges & Mastropieri, 1995). Some teachers are fearful that inclusionary classrooms will increase their workload and hinder their overall effectiveness (Gellens, 1996; Scruggs & Mastropeiri, 1996). It is generally accepted that in order for inclusion to be effective, classroom teachers must be receptive to the demands, and be educated to meet the diverse needs of children with disabilities (Gold et al., 1999; Garvar-Pinhas & Schmelkin, 1989). In order to achieve the full benefits of inclusion, Gold suggests that providing in service training for child care providers is not sufficient (Gold et al., 1999). Gold advocates a systemic approach to inclusion, incorporating mentoring and Special Instruction Consultants (SICs) along with a comprehensive training curriculum to enhance the success of inclusionary classrooms (Ibid).

A model for inclusion—The Enterprise Zone-Preschool Inclusion Project (EZ-PIP), conducted at the Mailman Center for Child Development, began in 1997 and was designed to expand, implement, evaluate, and disseminate a model inclusionary program that would increase quality child care services for all children. Previous research conducted at the center found instructional based methods that taught early care and education providers about the issues and concerns of children with disabilities to be limited in scope (Gold, Liepeck, Scott, & Benjamin-Wise, 1999). Although providers found knowledge about inclusion to be helpful, they had a difficult time implementing what they had learned. As a result of these and similar concerns, EZ-PIP was developed with three major components: 1) Training for child care providers, 2) Providing a Special Instruction Consultant as a field resource, and 3) Adding a teacher mentoring program where colleagues could seek out each other for advice, support, and guidance. Thus, the intention of EZ-PIP was to provide child care providers with the instruction and support needed in order to improve the quality of care provided to all children, with particular attention to those with disabilities.

Inclusionary practice training—The first part of EZ-PIP was to develop and deliver inclusion training to child care providers in the community (In addressing limitations of traditional, clinic-based programs, Wagner, et. al. (2000) describe community-based programs as an alternative mode of service delivery). The objective of the training was to increase the knowledge of inclusionary practices, increase awareness of issues related to inclusion, and help providers recognize children in need of referrals for evaluation. Twelve, two hour training sessions were developed. Each session was informal and filled with activities, videos, and reading materials to maximize the learning experience for the participants. Training was offered during naptime and money was provided to centers to pay for substitutes so participants could attend. Attendance at each session was required to earn a certificate of completion, which fulfilled the state's requirement of eight hours of in-service training each year for child care providers. Since training occurred during the school year over several months, child care providers were able to apply knowledge gained in training directly to their environment. If questions or concerns arose between training sessions, participants were encouraged to bring these up for group discussion at future meetings.

Special instruction consultant (SIC)—The SICs are graduate students who have training in inclusionary practices in addition to formal special education courses. The model was adapted from Florida's Department of Health for children 0 to 3 years of age and adjusted for use with children ages 3 to 5. SICs supplied the child care providers with instructional techniques, professional advice, assistance with refining their daily schedules, and ideas to redesign their classroom environment. Providers could utilize the SIC's services whenever the need arose. Participants requested an SIC to visit their class. A notebook was developed for each center, which contained important information to guide the teachers through the identification and evaluation process for children with possible disabilities. Action plans were then designed for children who were in the evaluation process. These plans included all pertinent information on progress, services, and diagnosis, when available, as well as recommendations from the SIC. An expected benefit was that teachers could use this information to work with each child who needed the services.

Mentoring—Another component of the EZ-PIP model is peer mentoring. Educating the child care providers is important, however, it does not ensure the continued success of inclusionary classrooms. Having an experienced child care educator available as a mentor can provide the support needed for providers to implement the information obtained through training (Odell, 1990). An important function of mentors is to help providers identify their own strengths and personal skills. As such, mentors empathize and communicate genuine feelings of acceptance, translate the art and science of teaching, and apply models of assistance according to the needs of the teachers (Head, Reiman, & Thies-Sprinthall, 1992).

Other measures of progress—In addition to the focus groups, quantitative measures were used to examine structural classroom changes and changes in teacher's ability to run a successful inclusionary classroom (i.e., interaction, scheduling) and to find out if there was a decrease of possible developmental delays of children in their classrooms. Preliminary analysis has uncovered statistically significant positive changes in classroom environment and curriculum and has also demonstrated a decrease in adjustment behavior problems for students in the classrooms of the teachers who have been trained. Two measures were used for this analysis: the Assessment Profile for Early Childhood Programs: Research Version (Profile; Abbott-Shimm & Sibley, 1995) designed for use as a research measure, used to provide quantitative measures of classroom and teaching practices that facilitate the learning and development of children in early childhood care facilities; and the Developmental Observation Checklist System (DOCS; Hresko, Miquel, Sherbenou, & Burton, 1994) a screening device for identifying younger children with potential developmental delays.

Methodology

Formative evaluation—Focus group interviewing, a method first used in the 1920s, is gaining prevalence in its use as a program evaluation tool, especially when the community's perspective needs to be heard. Program development efforts use focus groups to explore social, cultural, and consumer aspects of potential target population in order to reach and serve them more effectively. They have also become integral program evaluation tools for post-program, strategic planning, and needs assessment (Krueger, 1994). Since focus groups turn to community members as experts, the method fits well with the community-based program philosophy. This focus group was designed and used as a method for evaluating the processes in use, identifying areas for improvement, and then deriving strategies and plans for these improvements. Thus, the findings should not be interpreted as outcomes, but as indicators of the effectiveness of techniques in use and as idea generators.

Emergent themes—These focus group were conducted using a semi-standardized moderator's guide and were part of a multi-phase research design. Standardization allows for comparability between groups and saturation of data. However, the multi-phase, "emergent" design accommodates unique aspects of each group, in order to avoid what Merton (1990) refers to as "the fallacy of adhering to fixed questions." Generally, in using a standardized moderator's guide the questions and procedures must be carried through once entering the field, regardless of emergent and serendipitous findings. This evaluation design, however, is comprised of phases: Phase 1 (Exploration—semi-standardization); Phase 2 (greater-standardization); and Phase 3 (standardization). Phase 1 was completed with the focus groups described in this report. Data analysis led to common patterns in four informal, semi-structured focus groups. Those patterns, along with the goals and purposes of the evaluation, could be used to define key sections of a follow up moderator guide. Phase 3 calls for a total of for to six standardized focus groups so that data become saturated and "little new information emerges after the first few groups" (Morgan, 1996).

Research and development—Concurrent with the generation of new key themes, the focus groups are conducted as a part of the program's research/evaluation and development process. New understandings, drawn from the current focus groups, guide adjustments to the EZ-PIP. Thus, the second set of focus groups will revisit main themes after adjustments have been made with the objective of continuously improving the program based, in part, on the needs and reflections of the market. As with any product or system development process, focus group data are analyzed as one source of understanding. Behavioral data are also collected.

Moderator guide—EZ-PIP personnel drafted and developed the moderator guides. The moderator guide follows the design suggested by Sturges (1998) and include four internal sections including 1) introductory remarks and ground rules; 2) warm up questions, 3) the data; and 4) follow up and closing.[1] The strategic value of this design is that it gradually works into data collection while increasing participant comfort. The first section introduces the topic and describes how the focus group will be moderated. Section 2 builds rapport between participants, as well as between participants and the moderator. It also provides the moderator a chance to gauge how best to interact with each participant. Section 3, the longest section, usually lasts about 1-2 hours. It is the section in which in-depth investigation occurs. The last section, follow up, provides an opportunity to review and introduce topics, although its primary purpose is to recapitulate key points.

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[1] Additional steps are included for formal focus groups and groups conducted in specially-designed focus group facilities.

Moderating team—The moderating team consisted of EZ-PIP personnel. Dr. Castro moderated the first two groups (teachers and administrators) and Kenny and Steve (together) moderated the second two groups. It should be noted that Kenny also served as a SIC. For the groups conducted by a team, while one took the lead, the two worked in tandem having decided in advance who would be responsible for which sections. For each section, one person moderated, while the second took notes, ensured that the audiotape and videotape recorders were operating, and recorded ideas for additional questions for the acting moderator.

As in any focus group, moderators used the dynamics of the group to construct meaningful discussion about the core issues. Morgan (1996) asserts "what makes the discussion in focus groups more than the sum of separate individual interviews is the fact that the participants both query each other and explain themselves to each other." Moderators strived to gently sway the flow of conversation so that each participant could provide useful information that converged with or contrasted others' perspectives. To enable comparison of findings from these groups with those of others, all core questions were asked. Moderators used the core issues as guides and then explored unexpected findings with probes, at times allowing participants to wander slightly from the immediate topic.

Recruitment and sample—A random sample of twelve teachers who participated in at least 75 percent of the EZ-PIP training classes on inclusion (with the expectation of recruiting a minimum of eight participants) was selected. Twelve administrators were also chosen randomly from the pool of administrators who attended at least 75 percent of the EZ-PIP training classes. Individuals were contacted by telephone and were asked to participate. Those agreeing to participate were subsequently mailed additional information (i.e., map to the location). Each participant was informed they would receive 40 dollars for participating, that dinner would be provided for them upon arrival, and that their participation was voluntary. Two prospective participants were no shows.

Materials, equipment, and facility—To ensure accuracy in recording and reporting results, the team used audiotape-recorders to record the focus groups. They used videotape recorders to aid transcribers in identifying speakers on the audiotape. In addition to these methods, they took notes. The team brought an audiotape recorder, three hours of clean audiotapes, a video recorder, blank videotapes, and the moderators guide. Groups were held at two childcare centers that were served by EZ-PIP. The first two groups were held at a school centrally located to the southern childcare centers for participants located in that region. The second two groups were conducted at a school centrally located to the northern childcare centers for participants located in that region.

Data Handling and Analysis

The team used a thematic analysis approach (Agar, 1986; Sturges, 1998). Most audiotapes were transcribed verbatim. Inaudible and incomplete passages were omitted. Where possible, vernacular was typed verbatim, as were false starts and other language features not typically used in Standard written English. Observations made during the focus group were added in brackets and labeled OC for observer comment. Transcripts were proofread for accuracy and then formatted as DOS text with layout. The transcripts were then imported into ATLAS.ti, a qualitative software tool, where analysis was completed.

ATLAS.ti, which is based on Glaser and Strauss' (1967) grounded theory, provides researchers means of working with qualitative data by exploring emerging themes and developing data-derived theories. For this initial analysis, which was completed for the purpose of documenting evaluation of EZ-PIP, a basic, textual-level analysis approach was applied.[2] Textual-level research activities include segmenting documents into passages through coding and "chunking" quotes or important pieces of text. ATLAS.ti was particularly useful in providing a means for quickly retrieving, reorganizing and manipulating text selections and notes relevant to each theme, as those themes emerged.

Once the data were entered into ATLAS.ti, they were reviewed for repeating, overarching categories. Broad codes were designated for these categories. Once all meaningful data were categorized, finer coding was applied. Finer coding was completed using patterns emerging from within each coded set. Whenever possible, "in vivo codes" or insider terms were used for codes. Output for the finer-level codes were analyzed for cross-cutting themes. In all, 12 themes emerged. Those themes constitute the findings.

Findings

1. Descriptions of Children with Disabilities

Administrators and teachers provided their perspectives on children with disabilities. Commonly, center personnel described children with physical disabilities as easier to work with than those with behavioral disabilities. In most cases, teachers and administrators shared the notion that students with disabilities required additional attention, which some perceived as unfair to other students. In some cases, center personnel provided commented and dialogue about the effects social environment has on children's socio-emotional and behavioral well-being.

Physical is easier to work with than is behavior

Several administrators and teachers commented about working with different types of disabilities. Specifically, most commented that they found it easier to work with physical disabilities than exceptionalities related to behavior and emotion. An administrator said, "Sometimes with the disability, like physical disability, it's more easy for the teacher than behavior problems." Another administrator added that it was more likely to engage students with physical disabilities in individual activities, whereas those with emotional and behavioral problems required one-on-one assistance.

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[2] Conceptual level analysis would include constructing models based on textual-level analysis and relationships (causal and other associations) via a graphical network. This intensive approach could be applied in future analysis if additional data are collected.

> Especially those that have emotional and behavioral problems. They seem to need a lot more of our attention. They need so much one-on-one. We had a, a little autistic boy, I had one with down syndrome, and in essence they often didn't demand as much attention, because their behavior was such that they did a lot of their own sorts of things on their own.

A teacher recalled the differences between some of her students:

> I one time have a down syndrome, but like they said, that's not hard to manage, because you know they get along a stuff like that. But one time I have a child that he was I think some mental retardation, and he was very, very bad, cause he hit himself. He hit the other children. And he could not eat himself. He wet his pants and he was already five years.

Some commented that it was easier to work with students in wheelchairs because their disabilities were readily apparent. Students with behavioral problems, however, were perceived as more difficult to understand and, therefore, to be able to work with.

Some students were described as downright disruptive to class. One teacher said, "With the child that I'm thinking of he's what they call slightly Autistic and he's very disruptive." Another said:

> Sometimes even when the teacher works with them one in one their behavior is out of this world. I had that experience. The counselor came and talk to child. Went through the routine what you doing and showing and asking questions and everything and there were times when I mean the child just out of this world.

"A lot more one-on-one"

Teachers and administrators said that students with special needs require more individualized instruction and attention than do their other students. For instance, a teacher shared her experiences working with students with special needs:

> It takes a lot more personnel, trained people in a classroom, when you work with special needs. It doesn't matter what their special needs are. We had a couple of little children in ours, our center, that were not special needs as far as physical, but on just the borderline of autistic or something, and it took a lot more one-on-one with the child and the teacher to get that child to be a part of the classroom.

Another teacher recalled a particular student that required attention and whom she did not know how to manage. She said:

> Basically he was allowed to just roam around and do what he wanted to do and but then that's not fair to him and it's not fair to try to make him or to have so much energy on him that the other children get lost or they think that oh ok this is it's not circle time.

In a similar situation, a teacher recalled her inability to manage a child's behavior:

> I have this little girl who was taking up all of my energy because while the other kids are doing things she is just up and running around while the other kids are playing.

The influence of social environment on disability

In some cases, teachers shared their concern about the children's social environment at home. Some linked the social environment with the child's exceptionality. The following example of a teacher defining this situation, undergirds her perspective on the influence of social milieu on the child:

> All of them may not be documented on paper but there are a lot of people coming from single parents who are going through like their parents have drug addiction and all that and I have a children who just hurts because she is just very angry and another who is very hyper, but when I ask the mother she says that when he gets home he is just in front of the TV watching wrestling most of the night. So he is just being bombarded by these images and having to work with him within the environment and his actions are.

2. Socialization

Teachers and administrators provided their views on the social effect children had on each other in the classroom. This section includes teacher and administrator perspectives on the positive and negative influences and impacts students with disabilities have on other students and vice versa. Most participants identified with a perspective that including children with disabilities in their regular classrooms was an effective means of increasing social and academic skills of all students. For instance, an administrator described what she felt an essential purpose of inclusion:

> [With inclusion] the children learn to accept each other a little bit better, and it helps. Of those who have difficulty doing different tasks, I think it helps to boot strap them up, to be in the, so-called mainstream.

Several teachers commented that by having students with special needs in their regular classrooms, those with special needs develop social and other skills. One said, "And it gives them an opportunity to develop skills." Another teacher said:

> I think early inclusion is very necessary. It's very important because they get to be with other children of the same age group. They can learn from other children, and other children can also learn from a child with a special needs. It is very helpful for someone with a disability.

An administrator's input further supported this idea: "By putting them with other children that helps them. It may be a 'monkey see monkey do' thing, but to me it does help them. Without a doubt. It will help them reach further." Another said, "I think interaction the teacher with the children and the children with the children is very important. To me that's number one in any curriculum whatsoever."

Teachers reported seeing progress of students with special needs. A teacher commented on the language development of a student with special needs, but mentioned ongoing issues: "I have one, [child]. She's doing much better because I put her with kids who talk a lot and that's help her a lot. The only problem I have with her now is that she don't go to the bathroom. She just do it on her skirt."

Some teachers, representing a minority view, however, also described children with disabilities as having a negative effect on children in a "normal" classroom. For example, one teacher said:

> The purpose for including a child with a problem is to get a view of what supposed to be going on and what's going on in a normal classroom. If you bring this child in and he's so disruptive you're messing up the other children ability to learn and to grow.

Most teachers and administrators participating in the focus groups were positive about the impact of blending students with special needs into general classrooms. A handful of teachers held negative views. These negative views, however, were addressed to some degree in later discussions on the need for training and support.

3. Social Construction of Disability

Center personnel shared their perspectives on the meaning of disability. For some, disabilities were socially-constructed and, therefore, did not actually exist. In addition, center personnel shared their perspectives on the effects and meaningfulness of labels for various behaviors and exceptionalities.

Not always a disability

Some teachers and administrators shared the perspective that many children who are classified as having disabilities are not truly disabled; that they are misdiagnosed. One teacher said:

> Sometimes things are looked at as disabilities, but they are not. For instance, we've had three children we thought had speech impairments and it just turns out that they can't hear right. They got tubes in their ears and they're fine. If you hear "blou blou blou" that's how you are going to say it. So it seemed like disabilities, but it just needed to be fixed.

In addition, embedded within the teacher's statement provides a better understanding of how that person views disabilities—perhaps that they are enduring and unsolvable.

An administrator provided an alternative perspective on ESE. Specifically, she shared a personal experience:

> I didn't take any drugs when I was pregnant with my son. He was announced with learning disabled when he was five because I brought it to the teacher's attention: "Why is my child playing all the time?" From there she said "Yep, he's learning disabled!" I brought it to his attention. Why is he always playing in this class? Every time I come in he's playing with blocks. Montessori method is that the child play with pretty much whatever lesson.

This statement also highlights the perceived need for obtaining background information, especially parent input, in the process of identifying difficulties.

"For me they're all the same"

Teachers and administrators shared their dislike for labels. In one focus group, the moderator asked whether all of the participants agreed with one participant's comment about disliking labels. All of the participants said something to the effect of, "We don't like to label them." A teacher remarked, "I don't like to label kids. For me they're all the same. Whatever problems they have we have to work with them, but it's not a custom they should belong in the group, with the regular kids." Labels indicated "red flags" for children, rather than serving to enhance learning opportunities for all children.

Labels build expectations

Participants shared their concern about the ways labels could potentially affect the expectations of children. For example, a participant commented that labels build expectations of students. When a child comes to the classroom with a label, then the teacher automatically treats the child differently from the other students without first assessing the child's ability level. It seemed that a concern was that students with labels are treated with emotion more than challenge. He said, "They put a lot of emphasis on the child. It wasn't like they can do this, they can do that. It was like they always wait 'til they arrive and they show them like a lot of love." Thus, children with labels are seen as less capable.

4. Ideas on Educating Children with Disabilities

When asked to describe the best ways to educate children with disabilities, several participants, including both teachers and administrators, simply said, "Like you would teach anyone else." A teacher added, "Bring them in the classroom and try to treat them like any other child in the classroom. No matter what the disability is, mainstream them like they're no different from anybody else." Teachers and administrators provided ideas on working with and educating children with disabilities. While they provided different interpretations of its meaning, most said that providing accommodations was important. Another recurring provision was to engage parents and, for some participants, working with parents was the first and most essential task. A point of difference was whether to include students with special educational needs in the same classroom as other children or to place them separately.

Accommodate
Most participants, including both administrators and teachers, made some varying suggestion in favor of accommodating students with special educational needs. For some, this meant providing additional attention in the regular classroom. For others, it meant providing resource personnel. And, for some, it meant placing special needs students into a separate classroom. One teacher, who had limited experience with students with exceptionalities, surmised:

> I would imagine that they hold certain things to certain limits and with regular daycare they don't have those limits so if he wants to reach he can. If he doesn't want to he doesn't have to.

Another teacher provided an example of an accommodation she provided a student who was having difficulties in class:

> I have a little girl and she had this habit where she would disappear and so I told them if you see her out, make sure you bring her back! She would go off on her own when it's too much for her like when there is a transition. She works and when she should be cleans up, she takes a book and goes to the table and under the table and hides. To accommodate her, we picked the cover of the table and tucked it up and so we could see her.

"Work with each kid's needs"—Participants commented on the need to work with each child's particular educational and personal needs. Teachers and administrators suggested providing extra assistance in terms of simplifying tasks, permitting students to sit out of particular tasks, or assisting with physical needs. For instance, one said, "You just might need to help them. If they have no arms you might need to hold them. If they can't walk you have to help them, but you have to keep them and they still have the capability of learning." Another suggested form of assistance was to develop child study teams: "Have the teacher and that person or the personnel working with the kids. Have meetings so you can discuss the problems you may encounter." Still another commented, "We have to have the help sensitive to the children's needs. They have to be sensitive. Very important. And cue into the individual needs of the children."

"Give attention and praise"—Teachers and administrators suggested giving special attention to special needs students. One teacher said, "You just have to get them involved. I mean give them a whole a lot of attention like the young guy in our school you just have to just praise him all the time and that helped a lot when he know that you love him and you praise him and you called on him." Another teacher provided an example of the negative impact of taking that attention to the extreme of consuming an inordinate amount of the teacher's time:

> One time I have a child that he was. I think some mental retardation. And he was very, very bad, 'cause he hit himself. He hit the other children, and he could not eat himself. He wet his pants and he was already five years. So he really needed one teacher only to be with him. He was in the classroom, yes, but a teacher needs to be with him. So, he cannot be just with everybody.

On a more optimistic note, another teacher offered, "I think you just have to get them involved. I mean give them a whole a lot of attention like the young guy in our school we gave him praise all the time and that helped a lot."

"Get the parent involved"
Administrators and teachers indicated the importance of working with parents to facilitate their work with students. While another section, later in this report, focuses on parent involvement, it is mentioned here as a factor to which participants alluded as an important facet to working with children with disabilities. An administrator recalled the low rate of parent sign off after several students had been identified with problems that center staff felt should be evaluated. She said, "All of them think the children are alright, and it's not so. We know the children have the speech problems for example and the behavior problems, but the parents don't like to accept that kids have problems." She and other administrators discussed the importance of educating, communicating with, and involving parents. One added, "I definitely say get the parent involved so that parent can know what to do and not just leave that child there."

"Monkey see, monkey do"
Several administrators and teachers suggested that children with disabilities would benefit most from being in the same class with other students. Part of the rationale for this was based in social reasons, described earlier, and part is based on notions of academic challenge. Some examples follow:

- "By putting them with other children that helps them. It may be a "monkey see monkey do" thing, but to me it does help them. Without a doubt. It will help them reach further."
- "The children learn to accept each other a little bit better, and it helps. Of those who have difficulty doing different tasks, I think it helps to boot strap them up, to be in the, so-called mainstream. I think it's great. I really do."
- "Not the whole day outcast the kids. They should be with the other kids, the regular kids."

"In a room where it is there level"
Some teachers and administrators shared their opinions that students with disabilities would be better served by personnel in an environment that separates them from children who do not have disabilities. For others, it was not so much a concern for students with disabilities as it was relief for the other students and the teacher. Note that while these perspectives would be seen as antiquated in contemporary public schools, they are included here to provide a baseline of teachers' beliefs about special needs and the best environment (whether least restrictive or not).

Segregate special education students—Some participants felt that it was in the best interest of students with special educational needs to place them separately because such placement would enable them to receive sufficient attention from a specially trained teacher, a smaller class size, and lower level instruction. One teacher said:

> Bring the special teacher then you work with a person who has a degree to work with these children then you learn from them. But if you have these 15 children, let's say there's 50 children in the school there is one here, two here, three here then it's hard. Make it easier for these two teachers that work together. Give them children that all about the same level and take the ones and put them in the same school but in a room where it's their level.

Another teacher suggested maintaining the students with special needs in the same classroom but separating them by ability level. That teacher said, "I think it would help if they were in inside the classroom with the children maybe giving the children the one-on-one attention while still with the other group children."

Move them up or move them down, but move them out!—Some teachers and administrators noted that students were moved out of the classroom to provide other students and the teacher some relief from distractions and inequitable levels of attention. In some cases, children are advanced to the next higher grade level (as a form of early anti-septic bouncing). For instance, one teacher recalled, "Sometimes we have to put someone in the older class because one develops too quick and are aggressive with the smaller children." Other times, children are held back as the following example illustrates:

> I had her the year before and in the three-year old classroom and I was like she needs to be up and so I got together all of the paper work and they was just keeping her back because of her behavior and I was like I think she needs to go up and she can recognize the alphabet in a three-year old class to me they was just keeping her back

5. Ideas on making inclusion work

Teachers and administrators provided a short list of surmised conceptual factors that help to facilitate implementation of and improve inclusion models at their centers. These included educating other children to accept students with special needs, staff buy-in to the practice of inclusion, having a staff that is sensitive and adequately trained, and sufficient planning time. The list also includes topics that were already covered, including accommodations for special needs students, adequate personnel training, and staff's ability to work with parents.

"Educate the other kids not to be mean"

Teachers called attention to the importance of acceptance of children with disabilities and the teacher's role in ensuring that acceptance among other children. One teacher said, "Educate the other kids not to be mean because they look a little different or they talk a little different, or they got some kind of problem. Not to be rude or laugh at them." Teachers suggested keeping the disability low profile. For instance, one teacher stressed including children with disabilities, "Without making a big issue about it."

Staff dedication and buy-in

Teachers and administrators commented on the importance of staff dedication and their level of belief and acceptance (buy-in) to the inclusion model in order for the model to work. In other words, staff commitment and their belief that the model was effective were essential for its success. For instance, an administrator said:

> The staff that is willing to learn, and use it. It's people that really, really want to do this. Not everybody that work with kids want to do this. They just do this for different purpose- because I make money, it's easy, because it's quick, because whatever. Not everybody is prepared to deal with kids.

Dedication was, in part, driven by outcomes. For teachers, the proof was in the successes of children with disabilities. One teacher recalled an instance in which a parent told the teacher that her daughter's performance was improving, "[The child] was much slower than the other children there and it was very hard, but the work paid off." Another teacher commented on the importance of seeing results, too, "Yeah if you don't see results it's hard to believe in that. It's gonna work but if it's not working for you. You don't see anything happening (Long Pause)." Dedication and buy-in was also seen as an innate social characteristic. An administrator said that some people possess this innate quality that enables them to work with special needs students: "It's one of those that just don't have the gift, there's the patience there that some have and some of them don't."

Staffing and resource issues
Administrative participants, together, illustrated a complex balancing act for center administrators; they must at once ensure high quality facilities, manageable class sizes, adequate training, and high quality teachers and services with limited funding. With the adoption of an inclusion model, they were required to ensure manageable teacher-student ratios and a staff that is well-prepared to work with students with special needs.

Decrease teacher-student ratios—Teachers shared the belief that successfully educating students with disabilities requires lower teacher: student ratios. For instance, a teacher said, "I believe that when there's children like that, the teacher should have less children in the class." Another added:

> Not only having lower ratio like the one to three ratio but a smaller classroom size all together is important even if you have a few teachers in the room so that maybe there's a 1 to 3, 1to 4 ratio. A larger group of kids for a child depending on what their special need is if it's too disruptive even if they have so many small groups if too many children are in one room might be too much for a child with disability to be able to handle.

As a teacher pointed out, however, it is not always at the discretion of center administrators to hire additional staff:

> There's other administrators that is above her it's out of her hands the staffing issues. It's the main thing she is on the same wavelength of what we want, she would love to have for inclusion program which we try our best. But sometimes when the other administration we don't have enough staff. Our classroom sizes are a little too big.

"The right staff"—Administrators commented about the need for additional of staff members. For example one said, "It takes a lot more personnel, trained people in a classroom, when you work with special needs. It doesn't matter what their special needs are." Another administrator said, "I firmly believe that if we have the right number of people to work with these children, it helps them elevate growth." And still another said, "I don't think it's so much putting a cap on the variety of disabilities as it is being sure you have the staff to work with those children."

Several focus group participants indicated the importance of having not only a sufficient number of staff members but also the most appropriate members for the needs of the center. Comments included the notion that the "right staff" would help to make all students comfortable. One of the keys to having the "right staff" was having the "gift" of patience. Another key is having adequate training and experience. A teacher explained:

> Often when you call your director for support for a misbehaved child or whatever they'll send you the little person on the totem because they're less likely to be doing anything and that's just a lot of times worst than having nobody because they don't know how to deal with that child.

In response to inadequate staff training and knowledge about students' learning and behavior difficulties, teachers shared the impression that oftentimes they are held responsible for ongoing problems in their classrooms.

Specialists on staff—Administrators and teachers shared their desire to have one or more specialists on staff that are familiar with the children and their difficulties and issues. Various terms were used—therapist, counselor, and mentor—to describe such a resource person. An administrator shared with the group her wish to have a speech therapist:

> You'd like to have like a speech therapist to come in and work with everybody. That'd be kind of the ideal. If you could have someone to do play therapy, someone to do occupational therapy, somebody to do speech therapy, and on a rotating basis.

Similarly, a teacher suggested adding a counselor to the staff "so when you run into a problem you could call somebody that's familiar with the child familiar with his needs that it wouldn't disrupt the rest of the class. She could just come in work group whatever situation he needs to be work through with." Another teacher shared the idea that by following up, mentors could play an important role in making inclusion work. They should "follow through with problems from the time they are contacted until the problem with a child is completely resolved." An administrator thought it would be useful to have a specialist on staff so that teachers could elicit feedback on strategies:

> They can say, 'You know … I saw you do XYZ with this little guy, and it wasn't working very well. Have you tried [ABC]?' I think that kind of support would help all of us in the classroom.

A teacher made a similar suggestion for working who have students with behavioral issues, "You would need someone to come in with [a disruptive] child so that when he's uncomfortable with the situation to remove them or just spend time with that child."

"Need time to coordinate"
Teachers indicated a need for planning time and time to schedule and coordinate events. Several, such as the one below, described the work day as offering no opportunity for planning or organizing:

> You need time the two teachers need the time and one of the things is that there is no time. You arrive there let's say at 7:30 and by the time you open the door you already have ten children behind you.

Another teacher focused on the need for time to coordinate with parents:

> Sometimes you don't have time to sit down for about 10 minutes and talk to the parents too because we need to work together. It's just parents and school together so we can try to set up like a schedule or routines or goals so they can follow that at home too. To help the teacher to do like an easy day with the child. It's difficult when you're by yourself and the parents coming to pick up the children and you don't have time to explain what happen during that day.

6. Parent Involvement

Teachers and administrators both recognized parent involvement as a key to the success of their center's program. They also, however, described parents as barriers or as holding contempt for the school personnel. The concerns were that parents do not participate, some are not receptive to requests for participation, and they do not follow center policy. Some participants were concerned about how parents are not consistent in their treatment of their children, which, in turn, affects behavior in class. In addition, center personnel saw it as their duty to inform and educate parents about education, disabilities, and center procedures.

Need for parent involvement
Teachers and administrators explicitly and implicitly illustrated their sense of a need for increased parental involvement at the centers. For some, involvement was a matter of getting parents to sign off on evaluation forms. Others were concerned about parents' apparent apathy toward cooperating or coordinating with center activities and child-centered issues. Participants also declared a need for parent involvement in order to access a fuller, more accurate understanding of the child and his or her difficulties. As one administrator remarked, "The teachers can learn equally as well from the parents. If the parents were able to be there and show them different things about their child."

"How we gonna get these parents in here?"
Administrators shared the opinion that parents are not committed to spending time at the school. In doing so, they listed some activities sponsored by centers to entice parents to attend. For example, one said:

> A lot to them just don't make the time. They don't make the commitment. We gotta figure how we we're gonna do this. That's what you're asking. How do we get these parents in here.

Another administrator added her perspective of low parent involvement:

> In the day care where I work participation it's very poor. There is nothing you can do to bring the parents. It's like they're leaving them there; it's a relief. "That is not my problem. It is you're business. You handle it." We can do Mother's Day lunch, they don't go; graduation they don't go; Father's Day they don't participate.

Another center administrator succinctly summed her experiences, in exasperation, "Yea. Well, I've tried everything."

In the views of some administrators, the degree of involvement is tied, in part, to the approach the school or center takes to encourage parent involvement. For instance, one administrator said:

> We work with families too and we have pretty good parent involvement. I guess it's the way that you approach the parent, or the way that if you look at it. I don't know how you guys do it, but our teachers are the ones that are, well, responsible you could say that and, and bring in the parents into classroom activities.

Participants shared the idea that without teacher's actively striving to make the contact with parents, there would be no parent involvement.

Some parents are not receptive

Teachers and administrators recalled examples of situations in which parents were unwilling to become involved in center activities or discussions about difficulties their children were facing. In recounting the events of one particular case, a teacher said:

> It's like the child we were trying to get the help the child needed but the parent was like `oh I don't have time, I can't be there.' If the parent would have cooperated I think would have been better but sometimes the parents don't want to cooperate or they don't want to accept that their child is a special need child.

Center personnel described how other parents reacted by claiming to be underqualified to make decisions about placement of their children. For instance, a teacher commented, "Sometimes they say 'you have to deal with that. That's why you're here. Deal with that.'"

Administrators and teachers felt that some parents were in denial about their children's difficulties in the centers. One said, "The parents they don't like to accept that the kids have problems." An administrator recalled a parent who became defensive whenever center personnel attempted to contact her about her child's difficulties:

> She said, "Well, what did so and so did to him?" She's always in the defenses. She would never sit down, have a conversation with you; she don't want to hear it. Point blank.

Another response participants described is to not respond at all. An administrator described a situation in which a decision needed to be made about a child's prospective placement. She said, "What do I do? Not leaving it up to the parent because I made and appointment for her mother. Didn't follow through."

For most administrators and teachers, these kinds of reactions from parents translated into ceasing further attempts at communication between the center and the family. An administrator said, "If you have a problem parent, you can't just go and talk to the parent through parent conferences or home visits."

Parents are not consistent with treatment of children

Teachers and administrators shared the belief that parents' inconsistent behavior toward their children is a barrier to service delivery. Specifically, they argued because parents often treat their children differently at different times children react inconsistently in the classroom. One described how parents would buy drinks for their children one morning and then leave the child crying for one on another morning. An administrator described the problem:

> The parent didn't educate the children, only give all the children one [drink]. Some day the parents can give all the children one and another day than give anything. We have trouble with the child because they have to go to the floor [tantrum].

Parents do not adhere to policy

Participants were concerned about those parents who do not comply with center policies. Participants described situations in which parents failed to sign and return required forms, to attend meetings, and to pick up children who were ill. An administrator recalled an example of the latter, "If the baby's sick, we would like for you to come pick him up take him to the doctor. You can bring him back if the doctor. [mocking the mother's voice] 'Well, I'm sorry. I work late I can't.'"

Administrators portrayed the need to be strict with parents in enforcing center policies. One said, "It has a lot to do with the rules of the day care center, because if a parent has take his child to the doctor I mean he has to take the child to the doctor no matter what." Another said the center provides an orientation to parents upon enrollment:

> One of the things we do when we get our children enrolled in our centers, and the first thing we do before they even come to the center. After they register, we talk to the parents. We tell them our rules and what we expect from them.

"Communication is the real, real thing"— Administrators made the case that their staff was required to be prepared to work with parents of children with special needs. Some offered that communication is the most important skill a teacher can possess. An administrator described communication as "the real, real thing." All agreed that center personnel must be able to speak

with parents regardless of ethnicity or personal difference. An administrator expounded her view on the importance of being able to communicate with all parents:

> You have a child with special needs and you may handle one parent one way with a special need and another parent a totally different way. You got to deal with that, to balance that, and know what's most important. And who will deal with it, and who won't.

Another administrator provided an example of a parent meeting in which a speaker presented on the effects of pesticides. The administrator described the parents as disengaged and possibly bored. But, when examples were provided the parents began listening and sat up attentively. She generalized the situation saying that different people need to hear information delivered in different ways.

A participant reminded one group that several ethnic groups were being served and that it was the responsibility of the center be able to communicate with a variety of cultures:

> Ours is such a mixed culture of Hispanic, Afro-Americans, and a few Creole, and then like me, you know? And this one group of people will trust me, where as another may not, they may go to a different teacher. So it depends on your centers, and which work you're going to do.

Must educate parents

Administrators and teachers said they felt it was important to educate parents about issues at the center, especially those pertaining to children with disabilities. Some teachers were more direct in their approach while others used less direct means. Center personnel held the notion that it was to their own benefit to encourage parent interest. A teacher said, "I definitely say get the parent involved so that parent can know what to do and not just leave that child there."

One participant shared her belief that it was important to communicate with parent the meaning of inclusion and provide reasons for inclusion versus separating the child. That teacher said:

> [Talk] to them about what inclusion is because that's your child and they wouldn't like for them to have them in a special place, so called. Because, they want them to be with everybody.

Another suggested involving parents in special needs training, "so that it makes it easier for them to accept that their child may be having some kind of learning disability. It helps them over that denial issue, so that they can see the differences." An administrator suggested setting up and facilitating support groups for parents of children with disabilities. Another administrator suggested using funds to host a weekly dinner. "If we have a dinner, parents will come, generally."

Teachers described less formal means, such as modeling behavior. One teacher succinctly described such an approach with the following statement:

> There are certain things that the mom wasn't doing and I would make up activities so that she would be alright and the girl wasn't keeping up with her appearance and so I made up an activity where I was keeping up with her appearance and so all of a sudden the grandmother started washing her hair and things like that.

7. Need for Training

Overall, teachers and administrators suggested improving the program by increasing the amount of training and enhancing its quality. Several teachers, when asked about ways the program could be improved said, "More education (others agreeing along), more training (Everyone at the same time suggesting different points)."

"They didn't get enough training"

Most participants, teachers and administrators, indicated, directly or indirectly, that current training is not sufficient for their needs. Most said that the training provided them with a rich base, but did not enable them to problem-solve or act, efficaciously. In other words, the training "touched the surface for all of us." An administrator said, "One of my staff concerns was that they didn't get enough training. That year of two hours a month just didn't happen. They needed more. It kind of wetted your appetite."

Teachers made similar comments, indicating that they had some notion of individual students' problems, but that they required additional training in order to act in what they perceived to be an appropriate manner. For example, a teacher said:

> The amount of training that I feel like we had been given we have just enough to know what is fixing to happen but yet we feel guilty because … Wow, I knew that was gonna happen but I just couldn't react because this was going on over here. And so you tend to feel guilty because you feel like their loses is yours because you let them down in some way.

Another teacher asserted that training would be more useful if teachers had sufficient knowledge to feel capable of acting. That is, it would be more useful if teachers could answer such questions as the ones asked by a teacher: "How do I deal with them in a classroom with the other children? What are some kind of technique that you that would benefit both of us to work together?"

"Teachers need to be more educated and stuff"

Teachers, such as the following, made a case that training would help to serve students' individual needs rather than their label: "I think that that the teachers need to be more educated and stuff and not to label a child once you find out that they have a disability." Other teachers mirrored the idea. For instance, one said:

> We have this one particular child that just gave us. We tried everything from our training to work with kids with behavior problems and it's like nothing helped her.

Teachers and administrators indicated particular areas in which training should focus. These included the ability to identify particular student needs, how to serve those needs, and how best to work with parents.

No training = no standards

Another concern, which is dealt with a bit more in the section on accreditation, was that the lack of training for all centers translates into inconsistent quality of care and services. An administrator shared:

> If every teacher that comes in has already had to take that class to become a preschool teacher then they're going to come in with some knowledge. Well right now its just pick and choose. Certain centers were picked to take this course.

8. Who should receive training?

Administrators shared that they are selective about whom they send to professional development. Some criteria included staff "buy-in," the need for sensitivity about students, possessing an interest in working with students, being professionally prepared, and, in the case of the training provided, the ability to speak English. Another issue was the amount of coverage administrators were able to provide their centers. The limitations of sending only selected personnel become an issue when considering employee turnover, as one administrator described, "We had maybe seven people and we have two left. So we only have two teachers that have any inkling of what going on."

"Not everybody that work with kids want to do this"

Administrators provided a list of criteria for those teachers whom they selected to receive the training. The list included the most committed and the most capable. The most capable were described as those who are sensitive and who are able to "cue into the individual needs of the children." An administrator pointed out:

> Not everybody that work with kids want to do this. They just do this for different purpose- because I make money, it's easy, because it's quick, because whatever. No everybody is prepared to deal with kids.

Another administrator commented that only the most committed teachers receive training:

> They're the one's who are getting all the in-service training throughout the year. Not because the law says I gotta have it. Because they're committed.

Willing and able

Another recurring criteria is the degree to which teachers are both "willing" and "able" to complete the training. For instance, a teacher said, "As their supervisors we would be able to identify the teachers that would be willing, or would be able to work with the special needs children, and focus on them, on training them, specifically with these children." Another teacher described, "We don't send everybody. We just send the one's that we feel, they were interested in that, and they were ready for that." Self-selection was also a criterion. An administrator said, however, that some of her staff did not want to pursue the training, "Some don't want to take that extra step and some are afraid to take that extra step."

"You need this and you can do it"
Teachers and administrators reported that a key to teachers buying in and feeling motivated to be trained is the amount of support they perceive from administrators. For instance, an administrator said, "I think that if you support them though, as a director, and give them support they need they'll go and they'll take off and do their work." A teachers shadowed this when she said, "The director too, to encourage the staff 'go you need this you can do it.'"

¿Ingles solamente?
Administrators strongly suggested adding training in Spanish. Administrators were particularly concerned about the fact that training was offered only in English. For instance, an administrator said that speaking English was the only criteria she used and that she would have sent the rest of her teachers had the training been offered in Spanish. Another administrator said that she sent the only two teachers she had on staff who spoke English. Another made the case:

> We work with Hispanic children only basically, the majority, 99 percent. That's why most of our teachers don't speak English. At that time, we only had two teachers that spoke English so we felt they could share the information with the other teachers and unfortunately none of them are working there now.

9. Effect of Mailman/EZ-PIP Training

Teachers and administrators made several comments about the training they were provided. Overall, they seemed to indicate an interest in the training and an appreciation for it, but saw room for improvement. These included comments about the ways training was provided and recommendations for improving the training, follow up, time and place for holding the training, and the perceived effect of the sessions.

Teachers and administrators focused on two facets of the training that they described as needing improvement. First, participants suggested that training be hands-on. And, tied closely with the first suggestion, participants suggested that videos be replaced or made more realistic.

"Hands on is the key"
When asked to describe the most effective way to train teachers about working with students with special needs, administrators agreed that hands on approaches were the most fruitful. For example, an administrator said, "Hands on is the key to it. To bring us into that atmosphere, bring us there. Put us in it." Another participant said:

> Everything we've learned we've learned by somebody talking to us. No one's ever taken us into a situation, which I think, we need. We need to be brought into those situations. We need to be brought into those classrooms were those teacher have already been educated and know what they are doing.

"I need to touch it and then I'll know"

Teachers and administrators complained about the accuracy and quality of the videos used in training. For instance, a teacher said, "When we saw the video for example, all the time the teacher have three, to or four children and two people but this is not reality." An administrator made a similar comment, "You can watch the video, but when it's really happening it's a totally different thing." Several participants said something to the effect of, "I need to see it for real, I need to touch it and then I'll know."

"Have a person come into our center"
Aside from hands-on, teachers and administrators said there should be more follow up with the training. Specifically, they wanted to have access to someone to whom they could direct questions and someone who could come to the center to help ensure proper implementation of the tenets of the training. For instance, an administrator suggested, "Have a person come into our center. We have these certain problems with these children can you come into our center and show us how to deal with it?"

¿Español?
As described in some detail in the section on who should receive training, the language of training was seen as problematic. Specifically, teachers and administrators want to see training offered in Spanish. Some also indicated the need for offering follow up in Spanish. An administrator said, "If a child speaks Spanish, the people that do the follow up should speak Spanish too."

When to come
While some participants suggested having classes after work, overall classes held in the evening were frowned upon. Administrators and teachers said they preferred not coming during the evening because of their children and families. "Well I gotta home, I gotta cook, I got my family too." An administrator pointed out a financial factor in holding evening classes:

> Unless you provide child caring for them, a lot of the money to pay somebody to baby-sit. A lot of them are single mothers with children; so they don't have a spouse that can baby-sit while they come into training.

An off-work time alternative was Saturday. This was seen as a way center personnel would not have to worry about their classrooms and could focus instead on the training. Other participants, however, said that Saturdays would have the same barriers as evenings, if not more. In addition, some center personnel hold second jobs in the evenings and on weekends.

Some shared the notion that training held during the workday would be better received and attended by staff. For instance, an administrator suggested extending the duration of sessions and holding them during the latter part of the day, "If you wanted to make the sessions longer say they were from one to five, and we'd get substitutes to come in then." But others complained that, if the training was away from the center, they would get caught in rush hour traffic. Others suggested holding the training at the center during naptime.

Where to come
Administrators shared concerns about the location of the training sessions. Several commented that they were held too far from center. They shared a desire for the sessions to be held at or close to the centers. Two barriers include coverage of classes during training and the fact that many teachers do not have their own transportation. An administrator suggested another program as a model:

> We have the opportunity to participate in Building Babies Brains and it was very near our center. For example at Sagrada Familia at maybe three the teacher can be on time and can come back on time. It was very helpful because, almost all the teachers participate.

Another participant suggested finding a location that was convenient to personnel from several centers.

Positive effects
Teachers and administrators provided evidence of perceived positive effects of the training. Some described the training as a bonding experience for teachers and as a way to begin sharing ideas, while others described the benefits to students such as trouble shooting and focusing on specific problems or difficulties.

Center personnel discussed the bonding experience fostered by the training. For instance, an administrator recalled, "I think it bonded our teachers together, tremendously." Another administrator described how this bonding experience helped to forge sensitivity, teamwork, and problem solving:

> It gave them a real sensitivity to the kids that we have that need the special help. So, it really bonded us together. Instead of having this kid, real pain, and how quick can we get him out of this center and it was like looked at like, " what can we do about this? Let's formulate the plan. How can we help him?"

Another administrator described her amazement at discovering her staff cooperating to ensure coverage in classrooms as a result of the training. Others focused on the notion that the training offered teachers and other center personnel a framework for sharing ideas. For example, an administrator recalled:

> We had ideas flying everywhere, and we never had that before. So, it really brought us all together. Even the one's that couldn't physically maybe deal with that child, also offered ideas.

An administrator described how she brought home lessons from the training and found them to be effective there: "For me it helped me a lot. Even I have a have a son he's five and he was behaving terrible. So I used that information as a sample in my home." Others described applying the techniques to their classes and seeing firsthand the positive impact. Teachers discussed becoming more cognizant of issues in their classrooms and spending more time observing their students. "I learn to observe more on certain things that the children did."

10. Special Instruction Consultant

The SICs encouraged and motivated teachers, especially in learning about inclusion. In addition, SICs were described as helpful, readily available, responsive, and providers of good information. At the same time, however, center personnel shared a handful of concerns about the consistency of services, the roles of SICs, effectiveness, and the amount of time SICs spent at each center.

Consistent

One of the most comment and most forceful complaints focused on the degree of SIC's consistency. Teachers and administrators complained that they did not know the schedule of SICs and did not know the purpose of their visits. An administrator summed it up, "That makes everybody's life easier if you could have consistency be number one." In at least one center, however, the administrator was made aware of the SIC's plans and activities. The teachers at that center found the SIC to be a regular and helpful resource. But, this was not the norm. Most teachers and administrators said that SICs did not uphold any sort of schedule. One administrator said:

> The support needs to stay there. Not just come by like once a week, or once a month, and then they disappear. Then that makes the teacher very frustrated. And you want to keep that even level and not have that frustration. And have the teacher and that person or the personnel working with the kids.

In addition to wanting consultants to hold regular, set times, administrators also said they wanted increased time with the SICs.

"We have to know the job description for these folks"

Another complaint was based on confusion about the role of SICs. For instance, an administrator commented, "We also have to know the job description for these folks. Number one. Then know when they're going to come?" Administrators described the activities of SICs at their centers to include consulting, instructing students, serving as play therapists, and classroom assistants. One center, where there was already a paid staff member responsible for providing assistance, did not know what role the SIC was to assume.

"Blending in with the furniture"

Another recurring issue questioned the usefulness of the SICs in solving problems. Some teachers complained about not being able to contact SICs when they needed them. Most of all, however, teachers and administrators were concerned about the perception that SICs had little, if any, impact. For instance, an administrator made the case:

> You get these other one's that were sent over, that they just kind of blending in with the furniture. You know? They didn't get themselves involved. We were just wondering what they were doing there.

Teachers shared a similar perspective. One teacher recalled talking with the SIC for advice on referring a child and then getting information that was not useful. The teacher further explained that there was no follow up.

> Sometimes she would tell you 'well let's refer this child to this place.' Well I referred a few children to many places and nothing has happened. I need somebody to evaluate this child. 'There's something wrong with them.' Then it's kinda ended there.

Teachers suggested that SICs follow on cases. In other words, teachers would prefer that SICs become familiar with cases and then troubleshoot in case a teacher's attempts to have a child evaluated or placed did not work. In at least one case, an administrator thought the SIC was helpful, but teachers held a different opinion about an SIC. Administrators described the SIC as always completing her paperwork on time and seeming to be organized. Teachers, on the other hand, saw her as working only with paperwork:

> When she came it was kind of like 'what paper work now.' She seemed like a paper work person for me than someone that I can really turn too and talk to or ask questions to. I just really didn't see her for me as a benefit.

Several teachers complained about the ways SICs hampered their CDA training. Specifically, some said they were not permitted to complete the training for which they had invested much time.

11. Mentor Model

Administrators and teachers, overall, shared their enthusiasm about having access to a mentor. Some reported acquiring useful information from mentors. Most participants, however, were critical of the mentoring they received. Specific concerns included:

- Lack of mentor follow though on problems and issues,
- Poor planning,
- Inconsistent visits,
- Mentor turnover,
- Short amount of time spent on-site,
- Low levels of comfort and rapport,
- Sense of low effectiveness of assistance received, and
- Obscure roles.

The mentoring component was described as the weakest element of EZ-PIP. For instance, when asked what they would change about EZ-PIP, an administrator said, "Probably the mentoring." Others mimicked the first respondent. Another administrator agreed," The mentor. What was the purpose of the mentor? What was she supposed to help in?"

"Never happened"

Administrators shared their concerns about follow through on recruitment to become a mentor. One administrator shared an experience with a representative of the EZ-PIP team:

> One day in a course we had people visit and every one of them was together with the student. Like me for example we had one and she told us about what she learned

> in a program about working with children, but only that never see again. When they explained she told us that we had a mentor for every center but never happened. And we start to learn about it, because in the future we will be mentor at the other centers. That's what they told us. But never happened.

Mentoring should be planned and consistent

Heard more than any other concern throughout the four focus groups was that mentors were inconsistent in their visits and their plans and that the same centers saw several mentors come and go. "The support needs to stay there, not just come, come by like once a week, or once a month, and then they disappear." Some were not even sure whether the person coming to the center once in the distant past was a mentor or not:

> We didn't have a mentor come. We had someone come like maybe twice and then she moved I think or something happened. I remember her being in my classroom at least once. She kind of helped out as if she was one of my assistants.

Another administrator echoed:

> Its seems like we've had maybe five or six different mentors at different times, which made kind of chaotic. Because, you know, they don't know which kid they left of on, and the kids would actually move or whatever, and we'd get help for them on our own, and, so things were kind of little strange with this mentoring.

And another said:

> To have so many different ones coming in over a period of time. Every time somebody different would come in. We would have to take the time to explain to them where the mentor before them had gotten with that child, or what they had done up to that point, with that child.

An important point made by several participants was that in mentors are consistent; "they will familiarize themselves with that child." This enables the mentor and teacher to work together to implement a plan of action and then follow through with that plan while monitoring progress. Another said, "The consistency of a mentor coming regularly, the same one, where they would get more familiar with the children."

Teachers and administrators were also concerned about having a common plan. As one participant stated, "We need to know the direction they're going in." From comments and discussion, it was clear that center personnel were often left confused by mentor visits and were unsure how mentors were to be utilized. For example, an administrator said:

> If these mentors came out with a plan in mind, on paper, and had something to and then to follow up when they came back to see, "hey where did you progress from here?" Instead of giving them a blank book with a journal, where you had no idea where you're going, especially somebody who's never documented before. I think if they were shown how, and they had a plan of action, and they did that with each

> start with the child that's given them the most problems. Because, usually we're pulling our hair out, and we're happy to see that person, but you just need to know which direction to go to.

Another administrator echoed the response with, "I think a mentor program could work. I think it would be great to have somebody who knew what they're doing, and just do some role modeling with the teacher. But to have a plan is what you need." An administrator suggested having a planning meeting to ensure that everyone was on the same page. "If a director and the mentor and the group of the teachers that were gonna meet with them, met together, I think that would be more comfortable for everybody." Another important piece of information is that teachers and administrators did not know the role of mentors. Several participants said that they did not know the plan, the role, or how to facilitate the mentor's visits.

Time

Administrators and teachers commented about the coordination and duration of mentor visits. Some said that mentors came at times that were not convenient. For instance, a teacehr said:

> Often when she would come it wouldn't be a good time to be able to talk to her. You've got the kids that you still happen to deal with and even if they sent you another teacher into the room you were still expected to be there and if the kids are used to coming to you with their situation.

Another teacher shared, "When I'm with my class, I'm with my class. Whoever comes or goes I can't comfortably carry on a conversation with somebody while my class is." Another said, mentors "need more time in the classroom. Not just to come in and say `ok what can I help you with.' To come in to observe and make suggestions on the ways we can improve to help children."

Other participants were concerned about the duration of each visit. One demanded that mentors, quite simply, "Spend more time." The request for additional time was, in part, related to perceived unequal distribution of time: "Some of the teachers had a time did feel short change because some of the other teachers was getting the mentor's time." One teacher described how her mentor fortuitously came at a good time:

> She seems to just walk in when I need her the most and she always just went there she said one day. Sometimes, she says `well I was just in the neighborhood and I decided to drop by and see how you were doing. And that was not the days that she was supposed to come.

Comfort and rapport

Participants shared concerns about the perceived low levels of comfort and rapport between mentors and teachers. In many cases, mentors were depicted as coming into the classroom without greeting or otherwise establishing a connection with the teacher. The result was poor communication, discomfort for the teachers, and discomfort for the students.

An administrator shared a feeling with which other participants identified:

> If just anybody walks up to me, and starts asking me questions, I'm not gonna be comfortable with that person, because I don't know that person. And that's what happened here. The teachers weren't comfortable, because they didn't know that person enough.

Some posited consistency in center visits as an essential element of rapport building. For instance, a participant said:

> It's gotta be consistent so that they develop a rapport with that teacher. Because, the first two or three visits, you're not going to say, "Oh well I might, 'cause I gotta a big mouth. But most teachers are gonna feel a little bit threatened, so you almost gotta build a bond there. Maybe it means going to have a cup of coffee somewhere.

An administrator recalled watching a teacher and a mentor interact:

> I saw this mentor going over there, and I didn't see a true communication between them. It was like, "How is everything? Is everything Ok?" And then when she left, "Oh you know what this kid is getting sick."

Some described mentors as being disconnected from and un familiar with students and thought they ought to become familiar with children and their particular issues. For instance:

> They don't even know the kids. I mean, the one that is giving problems. That's why the teachers don't feel like, "Yes, this is the right person to go, or this is the person that I need to go." Because they know that the mentors don't know the kids.

Efficacy

Another area of concern shared about mentors was efficacy of the mentor model and the quality of personnel participating in it. Administrators and teachers commented about the apparent lack of knowledge mentors displayed. For instance, a participant said, "They didn't seem to know what they were doing, and my girls were even questioning their abilities to help." A teacher said, "I didn't feel like she had resources available that I couldn't get to. I could find the same resources that she had with probably less than a headache." Another added, " I didn't see no action. It was just standing there and watching, observing. I don't know if that was the purpose, that was I don't know if that was supposed to be that was for." And, finally, "My Mentor Model was like it was like she wasn't even there. She was like no help at all for me for my classroom."

But, efficacy was not seen as a problem uniformly. Several administrators and teachers called attention to specific mentors who were perceived as helpful such as, "Corolla and Elizabeth both were very informative and would go out of their way to look up any information that you wanted. They made their selves available to me. I assume the rest of the girls felt comfortable with them." Once center personnel became aware of the range of mentor quality, they sought the "best ones." For instance, "It's like going to the same doctor. You don't want to switch doctors."

12. Accreditation

Participants described their perspectives on accreditation. While the specifics varied, most felt that accreditation helps to raise standards while, simultaneously, bring hardships to centers. Participants thought accreditation would be more meaningful if it were universal. An administrator said, "I think it's a good thing but I think it should be required of every school." Another administrator commented on the positive effect accreditation would have if it were statewide. She said that in many centers children simply, "watch TV all day." In the administrator focus groups, this belief was followed by a discussion about the ways accreditation is a factor in improving the quality of education, as well as some of the negative aspects of accreditation.

Accreditation and quality assurance

According to center administrators, standardization ensures that teachers and center personnel do not "slack" and ensures high quality at the centers. Administrators made comments about accreditation such as it "keeps you on your toes. Those people are going to be coming in watching. It keeps you going. You're not going to slack off as easily." An administrator described the enduring effect of the preparation process on center personnel:

> Everything is built up for that one day when the evaluator comes out. Later you breathe a sigh of relief and then after you get all ready for the evaluation visit and you have everything prepared up. I think some of that stays with you later. You act as if there is someone watching you. You act as if you are a professional.

Several specific benefits of accreditation were described. One benefit was the additional attention for students. For instance, an administrator said, "Well, it's good for the children; the better part is for the children. The children have more attention from the teacher and it's very helpful." Another benefit was that is ensures the availability of important materials:

> Being accredited you have to have what it takes for the children to be able to learn in the proper manner. So in that way it at least helps the children because they do have the proper materials to learn.

While holding reservations about how financial and strategic drawbacks, administrators linked lower student-teacher ratio to improved quality of education for students. One said, "Actually it would be great to have 1 to 10 children. After all, I wouldn't want to have to watch more than 3 infants myself. It would be great." Accreditation also ensures the highest quality teachers and teaching practices. An administrator summed this point, succinctly:

> It means that you are the best at what you do. You have the best teachers, the best materials, the teachers know what they are doing. They are certified in the areas they are teaching.

Teachers echoed this perspective with comments such as, "The teachers are certified and they have the children in that room and you want to be sure that what they are teaching is appropriate for them." Another teacher posited that the main purpose of accreditation is that, "They want to know that the children are getting good care." Another said, "They're getting quality care. Care in that area."

Downsides of Accreditation

Several administrators commented on the difficulties of maintaining ratios as they are. For example, one said, "You're in business to make some money, not to make a killing, but to make something." Another administrator pointed out:

> The area that we're in we can't charge big, high tuition. And through child development we can't charge big, high tuition, so we need to keep our salary at a certain level. So if we have to cut our ratios down, we really can't give anyone a raise.

Administrators described the hardships of balancing tuition costs and paying teacher salaries. For instance, one administrator argued, "We can't because according to their standards it's already ten to one. So they want the other teacher for that five. It doesn't make sense." For infants, the requirements are even greater. An administrator described the need for three to one ratio. She continued describing the effect on tuition: "That means that you have to go up on your tuition you can't afford to pay a teacher for three children if you are not making that money." Some administrators pointed out that with additional teachers there also comes a need for more space. "That would mean more square footage, and where would you possibly come up with that space? There's no way and if they come in and see us with six we would be written up."

Assessments and instruments

When asked to discuss assessments, teachers' responses were terse. They did make it clear that they do not like assessments. One teacher simply said, "I hate that time a year!" Others stated, "I dislike assessment." In response to a probe on the latter comment, one teacher said, "I don't think they're fair. I think they only work the moments that they were given what happens 10 minutes from now has totally wiped it off the board." Teachers also shared some ideas about improving the process to get to more authentic assessments. Among these were having a person with whom the child is familiar conduct the assessment, "I know a couple of people who do assessments on the children and the children don't know you so they are not going to open up. They are not going to talk and answer questions and build the blocks." Another teachers shared the idea is to be systematic in the assessment process. A teacher said:

> I do [assessments] usually when a child enters my room and then I keep up on it as the child progresses. If you're able to keep track of progresses that a child is making then you can go back once a child has or whatever and you can look at that assessment and you can say `well he started here and he went to here' and we were able move him forward because he made these advances.

Recommendations and Discussion

Not all of the following recommendations are executable and efficacious. When compared with existing literature, some themes suggest reconsidering currently-used methods. In other cases, the findings alone suggest a need for change.

Program-level

Context—These themes provide a glimpse into the ways teachers and administrators think about children with disabilities inclusion and the ways they might improve EZ-PIP training and follow up activities. The information assembled here supports the need for an approach that turns to consumers for input in planning and development as a form of continuous improvement of EZ-PIP.

Quality Assurance—Mentors and SICs must be carefully screened and trained. This includes seeking and developing technical, organizational, and personal skills. Since time seemed to be a recurring problem—people were over committed—perhaps drawing from a pool of retired exemplary educators is an option.

Improve mentor training—The concept of mentors was well received, but the implementation of it was not. Mentors should be informed professionals who are capable of providing professional advice. Graduate students can be capable of doing this, but only with the same appropriate buy in, training, and desire participants of the focus groups described for personnel in their centers.

Spanish—Given the availability of language resources at the University of Miami and the fact that much of the client base (centers throughout Miami-Dade County and the South Florida region) speak Spanish, it seems reasonable that the next iteration of the EZ-PIP include training and follow up in that language. After reviewing the market base, similar consideration might be made for Haitian Creole speakers. In addition, if the EZ-PIP is to be implemented on a wider basis (nationally), additional languages might be considered.

Provide best practices in parent involvement—Teachers and administrators seemed to be floundering with ways to entice parents to enter and participate in activities at the centers. Perhaps this could be incorporated into the EZ-PIP training.

Planning and organization—Throughout the focus groups, teachers and administrators shared their concerns about not knowing the roles of various participants in the EZ-PIP, were constrained by the locations and times of training, and were visited by mentors and SICs without notice and at times that were not convenient. Much, if not all, of these concerns can be resolved with coordination of events.

Ensure teachers understand the importance and purpose of each aspect of EZ-PIP—Teachers, it seemed, did not fully understand the importance of assessments and evaluations and so they did not have much to say about them. In addition, they did not know what to expect from SICs and mentors.

Project-level

The following recommendations pertain to project management and coordination

Conflict of interest and influence of results—An area of concern is the possible conflict of interest in having SIC attend focus groups and participating as a moderator. If the purpose is to have participants speak freely about all aspects of the program, no other stakeholders should be present. Moderators must be disinterested, although well-informed, knowledge brokers.

Triangulation—It is important to triangulate findings by collecting data from multiple sources and using multiple methods in order to ensure credibility of findings. The findings reported here are based on patterns found throughout the four focus groups. (Observations or reports provided by only a single participant were omitted.) Even so, the results should be compared to findings from other sources. For instance, the EZ-PIP team found that the participating centers now have 10 children with diagnosed disabilities receiving after school care, 48 in the process of evaluation, and 27 who are waiting for assessment, having been identified by their providers since becoming involved with EZ-PIP. The perceptual findings, process data and behavioral observations should be examined together, or conjointly, in order to gain a better understanding of overall impact and efficacy.

Additional sources of data could include a questionnaire such as the 60-item Continuous School Improvement Questionnaire (CSIQ: Regional Education Laboratory, 2001). This self- report instrument helps to provide snapshots of a school's efforts to transform its processes as a type of ongoing needs assessment. Its' six subscales measure various areas of continuous improvement. Another instrument worth considering is the Special Strategies Observation System (SSOS: Nesselrodt and Schaffer, 2000). The SSOS provides systematic classroom observation data on instructional and behavior management practices, engagement of students, groupings, and activities of all persons in the classroom.

Continuous Improvement

The immediate next step is to locally implement recommendations from this report, and others, if they are deemed cost effective and desirable. However, to consider full implementation, further scrutiny should be given to the specific patterns found in the focus groups. This will aid in the research and development continuous improvement process as the program expands its efforts to full regional implementation.

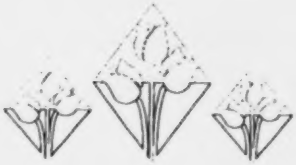
Continue the formative evaluation—Provided below is a list of steps for continuing the focus group study, moving toward standardization and, therefore, a more generalized applicability of the findings.

- Compare the findings with those from other data sources;
- Use the most important findings from all sources to guide development of a comprehensive R&D design;

- Make the most cost-effective modifications to EZ-PIP.

- Continuously collect and analyze data to study the effectiveness of the strategies and their implementation. The data include additional focus groups, observations of implementation and classroom practice, and surveys;

- Continue to make adjustments according to the analysis of those data.



Focus on Inclusion

PowerPoint Presentation

Susan Gold, Ed. D.
Patricia Donovan, M.S.Ed.

July 2002
Tampa, Florida

One Goal Summer Conference
Pre-conference on children with disabilities

Focus on Inclusion

- Results of the EZ-PIP focus groups

The Enterprise Zone-Preschool Inclusion Project

- Purpose- expand, implement, evaluate and disseminate a model inclusionary program
- Components- training, special instruction consultants, and mentoring

◆

Assumption #1

- Inclusion is beneficial for young children and their families

Assumption #2

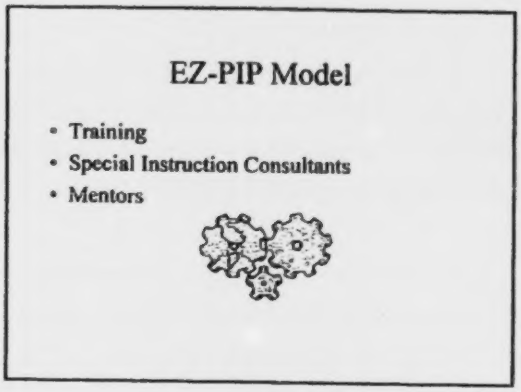
- Awareness and knowledge of inclusionary practices continues to expand

Assumption #3

- Inclusive programs have varying rates of effectiveness

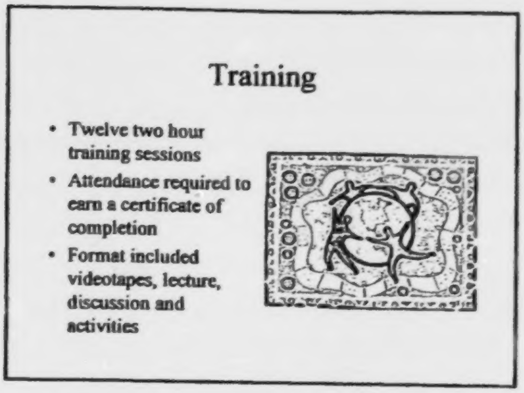
Training

- Providing in-service training for administrators, teachers, and parents is necessary but not sufficient on its own



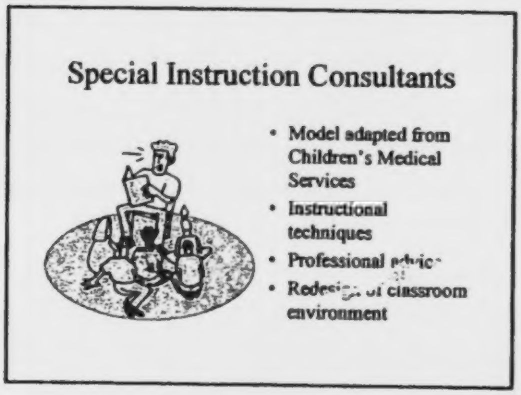
EZ-PIP Model

- Training
- Special Instruction Consultants
- Mentors



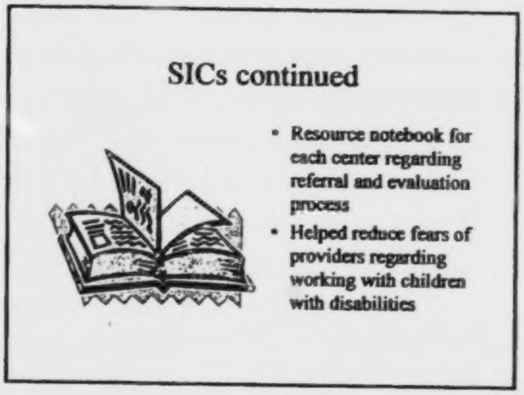
Training

- Twelve two hour training sessions
- Attendance required to earn a certificate of completion
- Format included videotapes, lecture, discussion and activities



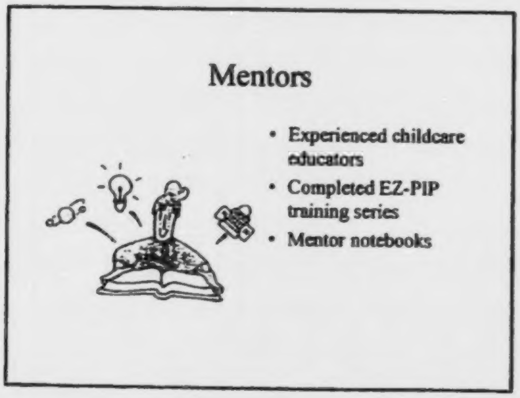
Special Instruction Consultants

- Model adapted from Children's Medical Services
- Instructional techniques
- Professional advice
- Redesign of classroom environment



SICs continued

- Resource notebook for each center regarding referral and evaluation process
- Helped reduce fears of providers regarding working with children with disabilities



Mentors

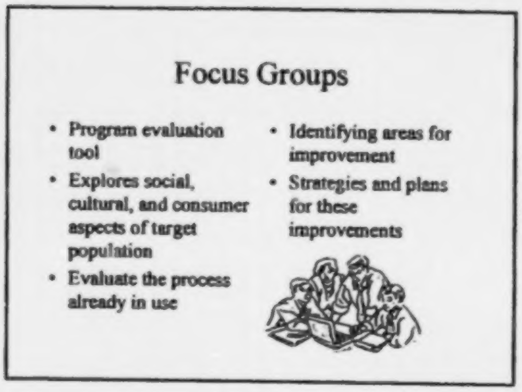
- Experienced childcare educators
- Completed EZ-PIP training series
- Mentor notebooks

Mentors continued

Help providers implement the information learned in the training

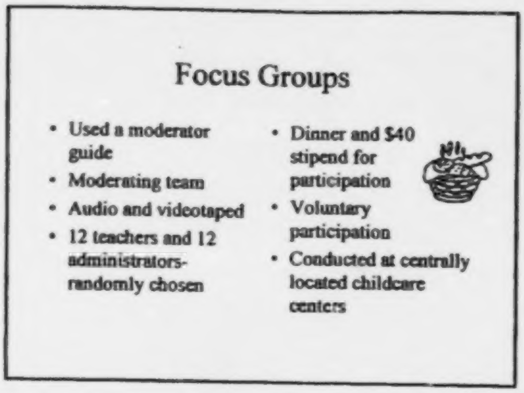
Help providers identify their own strengths and personal skills

Apply models of assistance according to the needs of the teachers



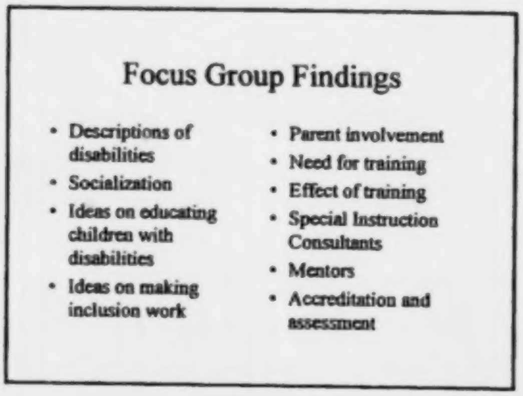
Focus Groups

- Program evaluation tool
- Explores social, cultural, and consumer aspects of target population
- Evaluate the process already in use
- Identifying areas for improvement
- Strategies and plans for these improvements



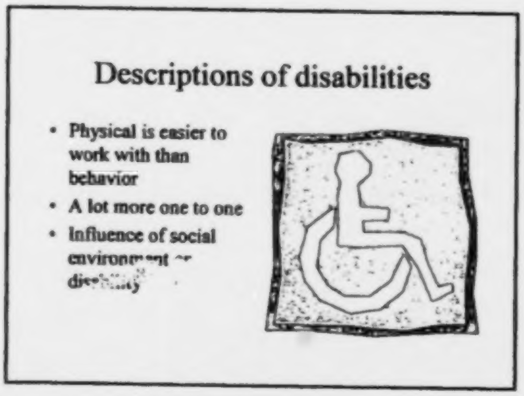
Focus Groups

- Used a moderator guide
- Moderating team
- Audio and videotaped
- 12 teachers and 12 administrators-randomly chosen
- Dinner and $40 stipend for participation
- Voluntary participation
- Conducted at centrally located childcare centers



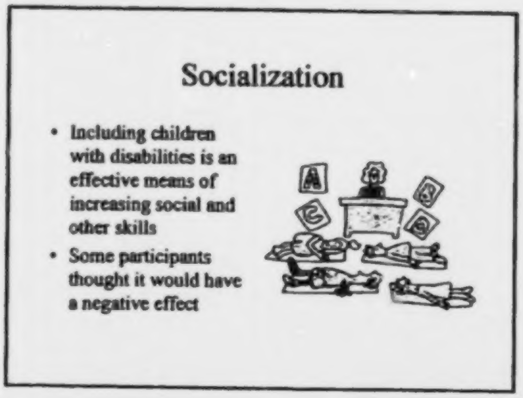
Focus Group Findings

- Descriptions of disabilities
- Socialization
- Ideas on educating children with disabilities
- Ideas on making inclusion work
- Parent involvement
- Need for training
- Effect of training
- Special Instruction Consultants
- Mentors
- Accreditation and assessment



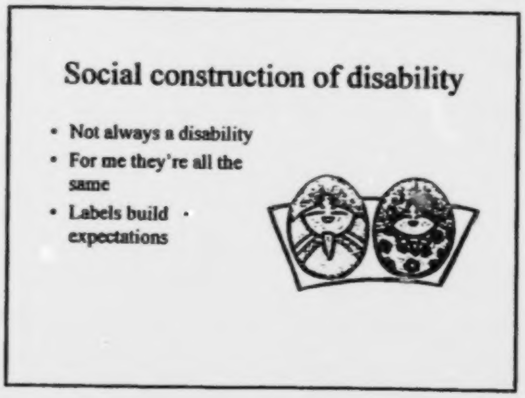
Descriptions of disabilities

- Physical is easier to work with than behavior
- A lot more one to one
- Influence of social environment on disability



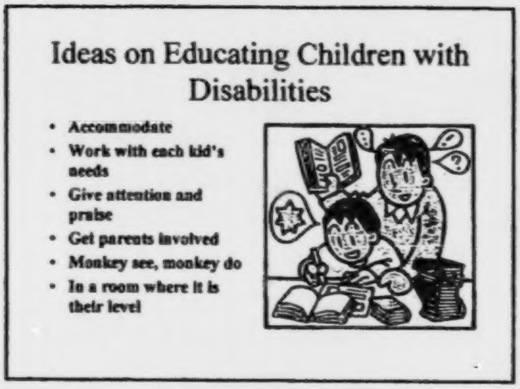
Socialization

- Including children with disabilities is an effective means of increasing social and other skills
- Some participants thought it would have a negative effect



Social construction of disability

- Not always a disability
- For me they're all the same
- Labels build expectations

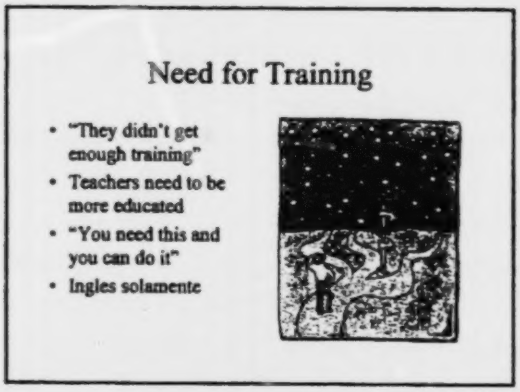


Ideas on Educating Children with Disabilities

- Accommodate
- Work with each kid's needs
- Give attention and praise
- Get parents involved
- Monkey see, monkey do
- In a room where it is their level

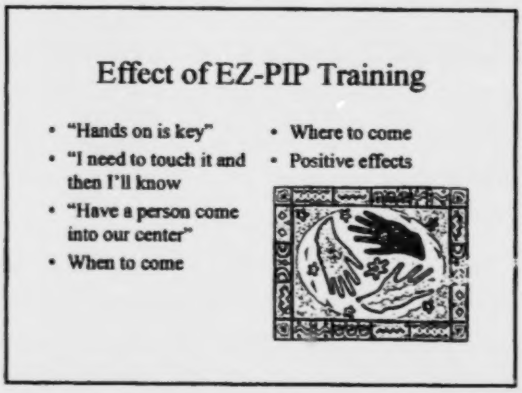
Parent Involvement

- Need for parent involvement
- "How we gonna get these parents in here?"
- Some parents are not receptive
- Parents are not consistent with treatment of children
- Parents do not adhere to policy
- Parents need education about center issues and disabilities



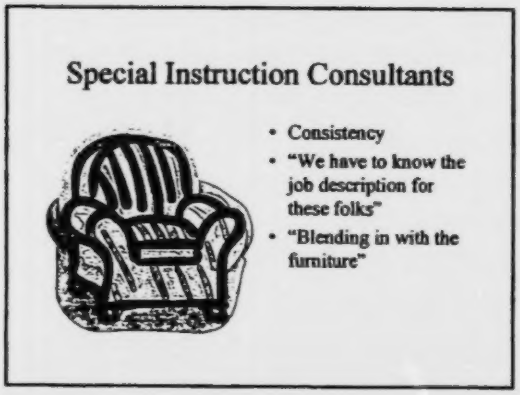
Need for Training

- "They didn't get enough training"
- Teachers need to be more educated
- "You need this and you can do it"
- Ingles solamente



Effect of EZ-PIP Training

- "Hands on is key"
- "I need to touch it and then I'll know
- "Have a person come into our center"
- When to come
- Where to come
- Positive effects

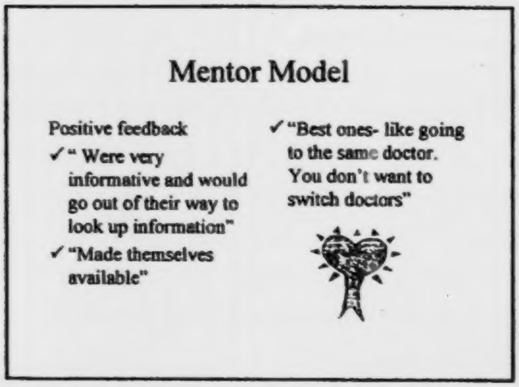


Special Instruction Consultants

- Consistency
- "We have to know the job description for these folks"
- "Blending in with the furniture"

Mentor Model

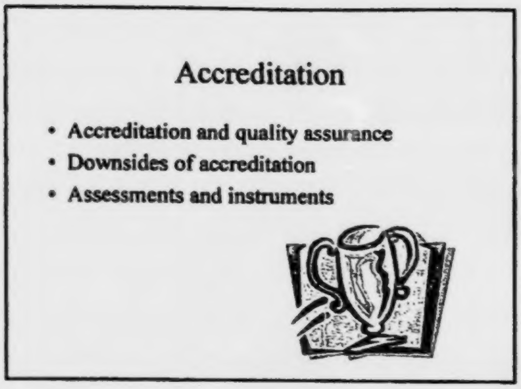
- Concerns
- ✓ Lack of follow-through
- ✓ Poor planning
- ✓ Inconsistent visits
- ✓ Turnover
- ✓ Short amount of time spent on site
- ✓ Low levels of comfort and rapport
- ✓ Sense of low effectiveness of assistance received
- ✓ Obscure roles



Mentor Model

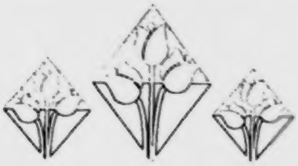
Positive feedback

- ✓ " Were very informative and would go out of their way to look up information"
- ✓ "Made themselves available"
- ✓ "Best ones- like going to the same doctor. You don't want to switch doctors"



Accreditation

- Accreditation and quality assurance
- Downsides of accreditation
- Assessments and instruments



The Enterprise Zone-Preschool Inclusion Project

Focus Group
Poster Presentation

A Model for Inclusion: Raising Awareness and Increasing Knowledge Among Child Care Providers

Susan Gold, Ed.D.
Tom Kennedy, M.A.
Blynda Murray

This work was supported in part by Grant No. H024B70071, the Enterprise Zone – Preschool Inclusion Project (EZ-PIP); U.S. Department of Education awarded to Susan Gold, Ed.D. at the University of Miami, Mailman Center for Childhood Development.

Abstract

The Enterprise Zone-Preschool Inclusion project (EZ-PIP) is designed to expand, implement, evaluate, and disseminate a model inclusionary program that will increase quality child care services for all children. This project serves a large number of children with disabilities and their families, living in areas designated as enterprise zones. Inclusion training, Special Instruction Consultants, and Mentoring components comprise the main aspects of our demonstration model. We assessed our program in order to increase the efficacy of future implementation. Both a quantitative and qualitative approach was used for program evaluation.

Introduction

- Inclusion is beneficial for young children and their families.*

- Awareness and knowledge of inclusionary practices continues to expand.

- Inclusive programs have varying rates of effectiveness.**

*(Baker, Wang, & Walberg, 1995;Chandler, 1994; Chang & Teramoto, 1987; Heller, Manning, Pavur, & Wagner, 1998; Parsons & McIntosh, 1988; Wolery & Wilbers, 1994)

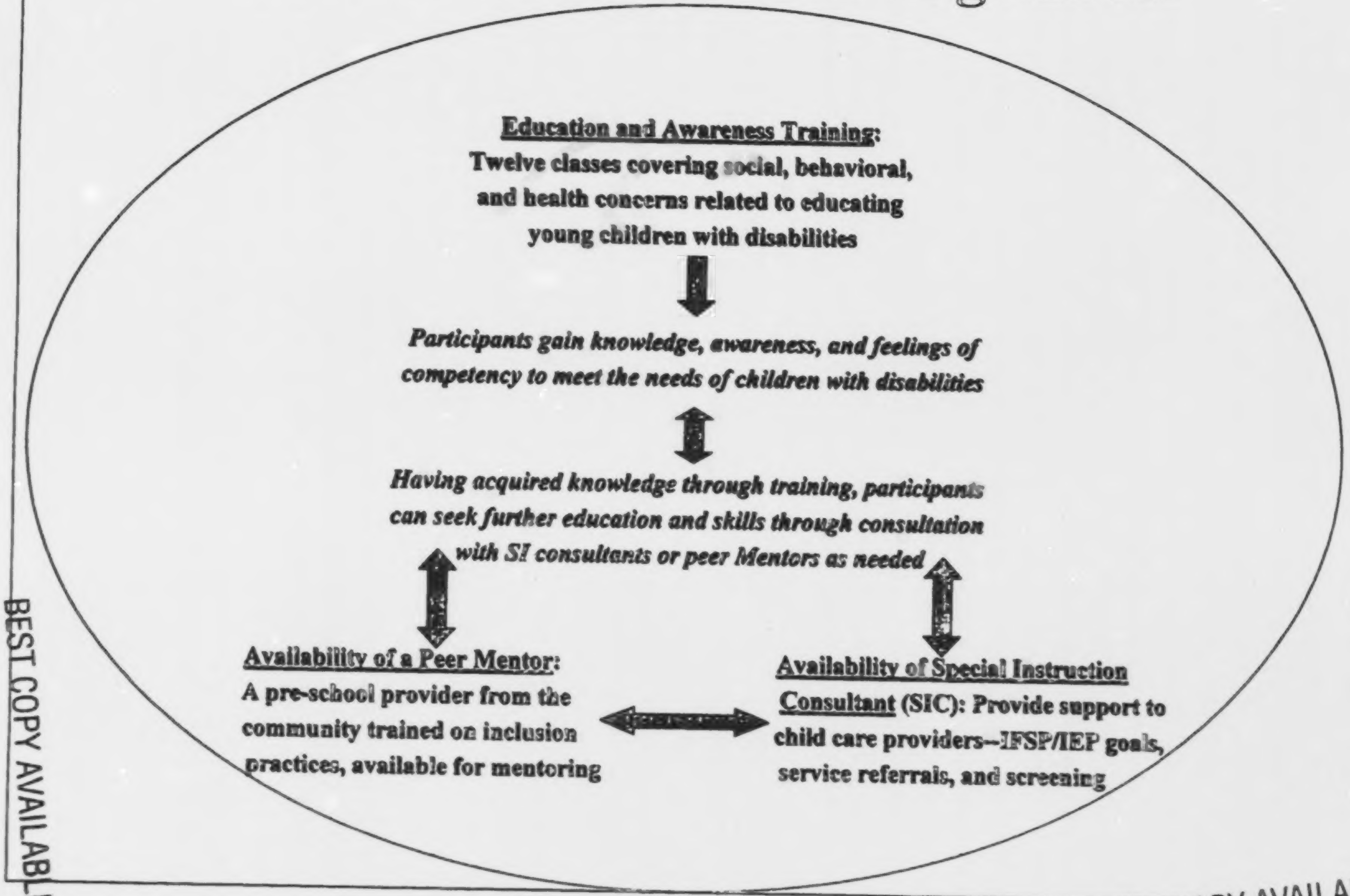
**(Kilngner, Vaughn, Hughes, Schumm, Elbaum, 1998; Manset & Semmel, 1997; Marston, 1997; Waldron & Mcleskey, 1998)

- **In order for inclusion to be effective, classroom teachers and parents must be receptive to children with disabilities and educated to meet their diverse needs.***

- **Providing in-service training for child care providers is necessary but not sufficient. Our model offers a systemic approach to inclusion, incorporating:**
  - 1) mentoring
  - 2) special instruction consultant (SIC)
  - 3) comprehensive education and awareness training. **(see model on next page)**

***(Gold, S., Liepeck, S., Scott, M., & Benjamin-Wise, S., 1999: Garvar-Pinhas & Schmelkin, 1989)**

EZ-PIP Inclusion Training Model



Education and Awareness Training:
Twelve classes covering social, behavioral, and health concerns related to educating young children with disabilities

Participants gain knowledge, awareness, and feelings of competency to meet the needs of children with disabilities

Having acquired knowledge through training, participants can seek further education and skills through consultation with SI consultants or peer Mentors as needed

Availability of a Peer Mentor:
A pre-school provider from the community trained on inclusion practices, available for mentoring

Availability of Special Instruction Consultant (SIC): Provide support to child care providers--IFSP/IEP goals, service referrals, and screening

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- **Education and Awareness Training:**
  Objectives:
    - 1) increase the knowledge of inclusionary practices
    - 2) increase awareness of issues related to inclusion
    - 3) help providers recognize children in need of referrals for evaluation
- **Twelve, two hour training sessions were developed. (see curriculum on next page)**
- **Attendance at each session was required to earn a certificate of completion, fulfilling Florida's requirement of 8 hours of in-service training each year for child care providers.**

EZ-PIP Training Curriculum

Session I Introduction: The Developing Brain

- Expectations of participants
- The effect the environment has on children
- The brain's development
- The impact of traumatic stress, neglect or abuse on young children
- The impact of early childhood providers on young children

Session II Learning a Teacher Screening Instrument

- Child development
- Inclusive child care settings and developmentally appropriate practices

Session III The Rationale & Philosophy of Inclusion

- What is inclusion
- Inclusion does not work without training and support
- The benefits of inclusion
- The laws, PL 94-142, 99-457(IDEA) and ADA
- Understand your community partners

Session IV Meeting Special Needs

- What are developmental disabilities
- Risk factors that may contribute to developing a disability

Session V Developing Appropriate Practices

- Developmentally appropriate practices and the importance of DAP
- Children learn through play
- Child/Adult interactions in the classrooms
- Scheduling and routines
- Classroom structure and materials

Session VI Universal Precautions

- Fears when dealing with children's health impairments
- Confidentiality
- Procedures for health and safety

Session VII Behavior Management

- Encouraging positive and managing negative behaviors
- Types of, and reasons for behavior problems
- Strategies

Session VIII Intellectual Development

- Overview of normal development
- Developmental disabilities and retardation
- Teaching techniques and general guidelines

Session IX Speech and Language Development

- Communication mechanisms
- Speech, sound and sentence development
- Conditions that affect speech and language development
- Indications for speech/language difficulties
- Screening tools for teachers

Session X Adapting the classrooms

- Accommodating children with disabilities in the classrooms
- Adapting the curriculum

Session XI Social Interaction and Teamwork

- Attitudes: respect for individual differences and dignity of children
- Peer tutoring and peer interaction
- Work as a teaching team to serve children with disabilities
- Needed instructional support and materials
- Work with the parents of children, assistant teacher, and administrators

Session XII The Next Step

- Consult administration with any concerns
- Discuss professional organizations
- Promote participation in community activities and child advocacy
- Video-ABC's of inclusion
- Summary of training sessions

- **Special Instruction Consultant (SIC)**: SICs supplied the providers with instructional techniques, professional advice, assistance with refining their daily schedules, and ideas to redesign their classroom environment.

- The SIC created a notebook developed for each center containing important information to guide the teachers through the identification and evaluation process for children with possible disabilities.

- The SIC helped to reduce the fears that many providers had towards working with children with disabilities.

- **Mentoring**: Having an experienced child care educator available as a mentor helps the provider implement the information obtained through training.*

- Mentors in our model were required to complete the EZ-PIP classroom training along with ten hours of inclusionary instruction adapted from the National Center for The Early Childhood Work Force. **

- Each mentor was provided with a “mentor’s notebook” that contained the training curriculum for the EZ-PIP inclusion course, activity handouts, community resource contact numbers, and techniques for professional development and classroom management.

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*Odell, S. J. (1990).

** Head, F. A., Reiman, A. J., & Theis-Sprinthall, L. (1992).

Subjects and Procedure

- **To assess the efficacy of our model, changes in the classroom and teaching practices were investigated.**
  - **39 teachers and their classrooms were examined over three years.**
  - **The Assessment Profile for Early Childhood Programs was used. The Profile consists of five Scales; Learning Environment, Scheduling, Curriculum, Interacting, and Individualizing (Abbott-Shimm & Sibley, 1995).**
- **Four semi-standardized focus groups were conducted to explore the perceptions, attitudes and beliefs of those who participated or continue to participate in the Enterprise Zone - Preschool Inclusion Project (EZ-PIP).**
  - **24 administrators and 24 child care teachers participated.**

Results

Assessment Profile:

- A significant improvement was observed in Learning Environment (e.g., classroom materials, room arrangement, and the promotion of a child's independence and individuality) ($\underline{t}(38) = -3.783$, $\underline{p}=.001$).
- A significant strengthening was seen in Curriculum (e.g., teacher fosters multicultural awareness and appreciation, alternative teaching techniques are used, children are encouraged to be active in guiding their own learning, and curriculum is individualized) ($\underline{t}(38) = -4.110$, $\underline{p}=.000$).
- Although improvements were demonstrated, there were no statistically significant changes in the Scheduling, Interacting and Individualizing scales.

Focus Groups:

- 1) Models of Inclusion—**Participants provided a list of factors that improve inclusion models at their centers. These were: educating other children to accept students with special needs, the ability of staff to buy-in to the practice of inclusion, having a sensitive and adequately trained staff, and sufficient planning time. Participants recognized parent involvement as a key to the success of the model. Center personnel saw it as their duty to inform and educate parents about education and disabilities.**

- 2) Mailman/EZ-PIP Training—**Overall, participants indicated an interest in the training and an appreciation for it. Some saw room for improvement, which included comments about the ways training was provided and recommendations for improving the training, follow up, the time and place for holding the training, and the perceived effect of the sessions.**

- 3) Mentor Model—Participants shared their enthusiasm about having access to a mentor. Some reported acquiring useful information from mentors. However, there were specific concerns: 1) lack of mentor follow though, 2) poor planning, 3) inconsistent visits, 4) mentor turnover, 5) short amount of time spent on-site, 6) low levels of comfort and rapport, 7) sense of little efficacy, and 8) obscure roles.

- 4) Special Instruction Consultant—SICs encouraged and motivated teachers, especially in learning about inclusion. They were described as helpful, readily available, responsive, and providers of good information. Concerns included the consistency of services, the specific roles and the amount of time SICs spent at each center.

- 5) Accreditation—Most felt that accreditation helps to raise standards while simultaneously bringing hardships to centers. Participants felt accreditation would be more meaningful if it were universal.

Discussion

- EZ-PIP provided training for 197 child care providers.
- Significant positive changes occurred in the Curriculum and Learning Environment of 39 centers that were evaluated.
- Because of EZ-PIP, 21 centers who never accepted or identified children with disabilities are now serving them.
- Because of EZ-PIP, at those 21 centers, 126 children with disabilities are now being served. Disabilities include Autistic Spectrum Disorder, Pervasive Developmental Disorder, Speech Language Disorder, Developmental Delay, and Attention Deficit Hyperactivity Disorder.
- Since the implementation of EZ-PIP:
  - A 5 year strategic plan for inclusion has been developed in Florida.
  - 2 SIC positions have been funded in Miami-Dade County.
  - There is one inclusion specialist in each of the 25 central agencies.
  - 4 new inclusion pilot projects (Clay, Broward, Pinellas, and Miami-Dade).
  - WAGES legislation in Florida mandates inclusion training for child care directors.

Focus Group Themes:

- Quality Assurance—Mentors and SICs must be carefully screened and trained. This includes seeking and developing technical, organizational, and personal skills. Since time was a recurring problem--people were over committed--perhaps drawing from a pool of retired exemplary educators is an option.
- Improve mentor training—The concept of mentors was well received, but the implementation of it was not. Mentors should be informed professionals who are capable of providing professional advice. Mentors must be members of the community with appropriate buy-in, training, and desire.
- Provide best practices in parent involvement—Teachers and administrators seemed to be floundering with ways to entice parents to enter and participate in activities at the centers. Perhaps this could be incorporated into the EZ-PIP training.
- Planning and organization—Throughout the focus groups, teachers and administrators shared their concerns about not knowing the roles of various participants in EZ-PIP, were constrained by the locations and times of training, and were visited by mentors and SICs at times that were not convenient.
- Ensure teachers understand the purpose of each aspect of EZ-PIP—Teachers did not fully understand the importance of assessments and evaluations .

The Enterprise Zone-Preschool Inclusion Project

Inclusion Assistance Grant

Inclusion Assistance Grant

In 1998, The Principal Investigator of the EZ-PIP project was invited to serve on a statewide committee designing a five-year strategic plan for inclusion of children in the State of Florida. As a direct result of participation in that planning process, three pilot projects were awarded to communities this state to implement inclusion projects. Each community was funded for three years. Information follows concerning each of these pilot projects. They are quite different from each other in nature and scope and all continue to be self-sustaining. They are:

1. The Inclusion Assistance Grant – Miami-Dade County, Florida
2. Clay County Inclusion Grant – Jacksonville, Florida
3. Broward County Inclusive Childcare Project – Ft. Lauderdale, Florida

Information concerning these three projects follows.

Additionally, Florida was one of 10 states that awarded a Map to Inclusive Child Care grant, in the second year of that project. The Principal Investigator was invited to participate in the statewide committee that went to Washington, D.C. in 1999 to attend the national institute.

Information concerning that project follows.

Miami-Dade School Readiness Coalition

Inclusion Assistance Grant
September 18, 2002

The **Inclusion Assistance Grant** is a three-year project sponsored by the Florida Developmental Disabilities Council and is managed by the Miami-Dade School Readiness Coalition. An Advisory Committee representing community agencies and service providers provides input and guidance to the project. The primary outcome of this grant is to increase the number of early care and education programs providing quality services to children with disabilities and special needs.

First Year

Under the management of KIDCO, a total of $50,000 was offered as small grants to center-based and family child care homes interested in providing quality care to children with disabilities and special needs in a natural environment. Only those sites that were currently serving children with disabilities and special needs were contacted. Sixty-three early care and educations (42 center-based and 21 family child care home) requested funding monies. A total of $47,105 was awarded to 4 family child care homes ($3,789) and 9 center-based ($43,316). The unused balance was used to finance training for early care and education staff. At the end of the year the number of children with disabilities and special needs did not increase, however, the staff involved received the necessary training to optimally serve this population as well as the typical population.

Second Year

Under the management of the Miami-Dade School Readiness Coalition, two part-time Special Instruction Consultant (SIC) were hired to provide technical assistance and training to caregivers working with children with disabilities or special needs. The SIC began their assignment by providing services to the 63 early care and education programs who applied during the first year. During this year the number of early care and education programs interested on providing care for children with disabilities and special needs increased significantly to a 101. Also, the SIC discovered that parents needed support by providing resource and referral services. Toward the end of the year, SIC's from other agencies began coordinating services in order to use the available resources in a more productive manner.

Third Year

As a joint project between the Miami-Dade School Readiness Coalition and the Miami-Dade Regional Policy Council the **N.E.E.D.** (Natural Environment Educational Development) was proposed. This initiative will bring all the key players who serve children with disabilities and special needs from birth to school age, together in order to increase productivity and reduce duplication of services.

The proposal states that Miami-Dade County shall be divided into 5 clusters (regions), each to be served by one Special Instruction Consultant (SIC). The following are the proposed key players:

a) 5 SIC's will be provided,
- 2 part-time paid by the Inclusion Assistance Grant
- 1 part-time paid by the Coalition
- 1 full-time from Family Central (Central Agency)
- 1 full-time from Miami-Dade County- Child Development Services (Central Agency)

b) Service providers (speech and hearing, physical therapy, etc) will identify N.E.E.D programs at which they are already working and will serve as SIC's in those programs.

c) Central Agencies full-time SIC's will serve as service coordinators for children who are referred within their own areas 50% of their time and as SIC's providing services 50% of their time.

d) FDLRS Screening Outreach Specialist will serve non-N.E.E.D. centers requiring Level Two screening by talking to program staff, doing developmental screening with the child, if necessary, and determining what referral to make.

e) FDRLS Screening Specialist will continue to perform preschool screening for centers that do not serve subsidized children.

Approximately 1,500 surveys were mailed to all licensed facilities, inquiring if they were serving or would like to serve children with disabilities and special needs. Around a 100 responses were received from center-based and family child care homes. These early care and educations programs will be participating of the N.E.E.D. initiative.

Ivette Aponte-Torres, Program Director
305-646-7242, itorres@childreadiness.org

FLORIDA DEVELOPMENTAL DISABILITIES COUNCIL

Inclusion Assistance Grant

Miami-Dade County School Readiness Coalition

3250 SW Third Ave/Fifth Floor
Miami, Fl 33129   305-646-7220

Announces the availability of

Special Instruction Consultant Services

This program is made possible through a grant from the Florida Developmental Disabilities Council. Our Special Instruction Consultants will visit your early care and education centers or family child care home and provide the following services, at no charge:

Observation and Feedback- With parental consent, we will observe children in your care and answer questions or concerns you may have about their development.

Classroom Strategies- If you are unsure about how to address the individual needs of children, we can help you develop strategies or assist in curriculum implementation. If the student has an **FSP** or **IEP**, we will be able to provide guidance to your staff.

Families as Partners- We will help prepare your staff for parent meetings and work with you to develop effective partnerships as you provide information and support to families. We will participate in meetings as per your request.

Service Linkage- We will provide information about the therapists' roles, responsibilities and how to link therapy goals into classroom routines and activities.

Training- We will help you create programs and services that coordinate with child care regulations, the Americans with Disabilities Act (ADA), and the Individuals with Disabilities Education Act (IDEA). Staff workshops both informational and hands-on can be conducted at times convenient to your schedule.

Information and Referral- We can provide a list of other resources and services available for children with special needs and their families and can assist you in the referral process.

For further information and to
schedule an appointment please call:
Bethany Sands
(305) 646-7221
or
Carola Matera
(305) 646-7224

FLORIDA DEVELOPMENTAL DISABILITIES COUNCIL

Inclusion Assistance Grant

Miami-Dade County School Readiness Coalition

Special Instruction Consultant Participation Agreement

The child care center or family child care home referenced below agrees to participate in the Inclusion Assistant Grant Special Instruction Consultant program. This program is design to offer at no cost, instructional assistance for early care and education teachers who are working with children diagnosed or suspected of having special needs or developmental delays. Funding will be provided for the Special Instruction Consultant by a grant received from the Florida Developmental Disabilities Council administered through the Miami-Dade County School Readiness Coalition.

Conditions of this agreement are as follows:

1. Maintain a current Dept of Children and Families certificate according to F.A.C. 65C-20 or 65C-22 and be in good standing with the licensing department.
2. Arrange time for staff to work with the Special Instruction Consultant.
3. Implement program plans developed with the Special Instruction Consultant for children with special needs.
4. Participate in an satisfaction survey of the staff and the families of children enrolled in the child care center or family child care home diagnosed or suspected of having special needs or developmental delays receiving the Special Instruction Consultant services.
5. Allow therapists and /or early intervention providers to work with children enrolled in the child care center or family child care home diagnosed with special needs or developmental delays when specified on the child's Family Support Plan or Individual Education Plan.
6. Provide information and participate in the Family Support Planning or Individual Education Plan process for children enrolled diagnosed with special needs or developmental delays served in the child care center or family child care home.
7. Participate in or assist with interagency coordination efforts. Participation may include participation at meetings, subscribing/reading minutes from such meetings, reviewing issues to be presented to such groups, and providing input on a timely basis into planning processes.
8. Have a written policy on the confidentiality of the records of staff and children that ensures that the facility or home will not disclose material child and personnel records without written consent from the parent/guardian and will adhere to procedural safeguard requirements for CMS Early Intervention Program or other authorized agency.
9. Implement an individual special instruction plan that is consistent with the Family Support Plan or Individual Education Plan. The initial plan is developed jointly by the early care and education teacher, the family, and others involved in the provision of services for the child (e.g., therapists). The plan addresses the needs of the child and the specific activities to address those needs which will be used during the child's participation in the child care program. Updates of the individual special instruction plan are developed with input from the individuals in the initial plan.
10. This agreement will be in effect from the date signed until terminated by the child care center or family child care home care provider or the Inclusion Assistance Grant Advisory Committee.

Child Care Center / Family Child Care Home ____

Owner / Operator / Director ____

Signature ____ Date______________

FLORIDA DEVELOPMENTAL DISABILITIES COUNCIL

Inclusion Assistance Grant

Miami-Dade County School Readiness Coalition

3250 SW Third Ave/Fifth Floor
Miami, Florida 33129

Special Instruction Consultant Services

The Special Instruction Consultant Service is a program that assists childcare providers by observing and offering support and new ideas for the early care and education center or family child care home through a grant from the Florida Developmental Disabilities Council. We would like your permission for a Special Instruction Consultant to observe your child and help us adapt and modify our environment to meet the individual needs of your child. Theses services are offered at NO charge. Thank you for allowing us to better care for your child.

Please check one:

_____ **I do** give permission for my child to be observed by the Special Instruction Consultant to assist with meeting this/her needs.

_____ **I do not** give permission for my child to be observed by the Special Instruction Consultant to assist with meeting his/her needs.

Child's Name	DOB	Parent/Guardian Signature	Date

Child Care Center	Address

Child Care Center Professional	Title	Telephone/fax

For further information or to speak with a Special Instruction Consultant call:

Bethany Sands
305-646-7221
or
Carola Matera
305-646-7224

NOTICE OF PARENT'S RIGHTS AND DUE PROCESS
NOTIFICACION DE LOS DERECHOS DE LOS PADRES Y DEL PROCESO LEGAL

Dear Parent:

Due process consists of all the procedures written into law to safeguard your rights and the rights of your children. An important provision of the due process procedure is your right to receive and provide notification, information and consent written in the language you understand best. Be sure to obtain and keep all pertinent notices, information and consents.

The following is a summary of the due process procedure:

- You have the right to a full evaluation of your child's individual educational needs, and to be notified of and participate in planning your child's assessment.
- Specialized testing and exchange of confidential information used in the assessment process may only take place if you give your consent.
- You have the right to see all relevant school records of your child, and to request the school to change any information you feel is incorrect or misleading.
- You have the right to be notified of, and participate in team meetings to develop an Individual Education program for your child.

If you disagree with any decisions made about your child you are urged to meet with the appropriate Head Start staff and Parent Policy council to resolve the differences. If you cannot come to a satisfactory decision as a result of this meeting, you may initiate the following due process procedure:

- You have the right to an impartial hearing to clarify disagreements concerning identification, assessment and/or placement decisions. You may file for this impartial hearing with the State Superintendent of Public Instruction.
- You may bring representatives to the hearing to help you advocate for your child.
- If a satisfactory decision cannot be reached at the fair hearing, you may initiate a civil legal action.

Estimado Sr./Sra.:

El proceso legal consiste de todos los procedimientos escritos en la ley para salvaguardar sus derechos y los derechos de sus hijos. Una provisión muy importante del proceso legal es el procedimiento que especifica su derecho a recibir y de ser provisto de notificaciones, información y permisos por escrito en el idioma que Usted entienda mejor. Asegúrese de obtener y guardar todas las notificaciones, información y permisos que incumban a su hijo/a.

Lo siguiente es un resumen de los procedimientos en el proceso legal:

- *Usted tiene el derecho a una evaluación completa de las necesidades educacionales individualizadas de su hijo/a. de ser notifcado y participar en la planificación de dicha evaluación de su hijo/a.*
- *Se requiere su permiso por escrito para todos los exámenes especializados, así como para poder intercambiar información considerada confidencial, que vaya a ser usada en el proceso de la evaluación de su hijo/a.*
- *Usted tiene el derecho de revisar todos los reportes escolares concernientes a su hijo/a, y el derecho a pedir que la escuela cambie aquella información que Usted crea que es incorrecta o inexacta.*
- *Usted tiene el derecho a ser notificado de antemano y a participar en las reuniones del equipo para desarrollar el Programa Educacional Individualizado (IEP) de su hijo/a.*

Si Usted no está de acuerdo con cualquier decisión que sea hecha sobre su hijo/a se le urge que se reuna con el personal apropiado de Head Start y la Junta de Poliza Familiar para solucionar ese desacuerdo. Si no puede llegar a una decisión satisfactoria como resultado de esa reunión Usted puede iniciar los siguientes procedimientos del proceso legal:

- *Usted tiene el derecho a una audiencia imparcial para clarificar el desacuerdo concerniente a la identificación, la evaluación y/o la decisión de donde colocan a su hijo/a. Usted puede pedir esta audiencia imparcial con el Superintendente Estatal de Instrucción Pública.*
- *Usted puede traer representantes a esta audiencia para ayudarlo en la abogacía de su hijo/a.*
- *Si no se puede llegar a una decisión satisfactoria en la audiencia, usted puede comenzar acción legal en la corte civil.*

FLORIDA DEVELOPMENTAL DISABILITIES COUNCIL

Inclusion Assistance Grant

KIDCO Child Care, Inc.
3628 N.E. 1st Court
Miami, Florida 33137
(305) 576-6990

Dr. Silvia La Villa
Project Chair

Michele D. Scott, M.S.
Project Manager

1998-1999 Final Report

Overview

The Inclusion Assistance Grant is a pilot project addressing the specific needs of child care providers in order to provide and inclusive environment for children with disabilities and special needs in child care service. The project was funded through a partnership with the Department of Children and Families (DCF) and the Developmental Disabilities Council (DDC) and awarded to the Miami-Dade County Public School Pre-Kindergarten Interagency Coordinating Council (Pre-K ICC). The objectives were to collaborate and coordinate services and resources within Miami-Dade County among key players, including but not limited to representatives of the Interagency Coordinating Council, Wages, TANF, education (Pre-K and other programs or services), Part H/C early intervention services, Head Start, business, civic, religious, parents, political organizations and child care providers.

KIDCO Child Care Inc. (the provider) was selected as the fiscal agent and coordinator for this project based on their experience, position within the community and their willingness to handle a project of this nature. This arrangement was necessary due to the Pre-K ICC's inability to handle financial matters. Initial correspondence with DDC served to outline the project objectives, establish budgetary requirements, develop criteria for an Advisory Committee and pilot communities, and detail a Plan of Action with time lines and responsibilities. It was understood prior to the project onset that awareness of the need for inclusion and training of providers must have already been established. The goal was to enhance available care for children with disabilities by providing appropriate funds, services, and supports through a collaborative knowledge base. The coordination of all identified funding sources available for child care settings offering care for children with disabilities and special needs then helping child care providers to access this resource was the mechanism of this project.

Planning

The initial responsibility assumed by the provider was to establish an Advisory Committee representing the various community agencies to offer guidance and to develop a coordinating function to oversee this initiative. The functions applied to all aspects of the Advisory Committee, including meetings, place, time agenda and minutes. Requests for committee members were addressed to all child care agencies, provider organizations and private industry through a variety of media. Willingness to participate and in-kind contribution was readily received from existing members of the former Pre-K ICC. This proved to be beneficial with arranging meeting times and defining existing sources of funding and service. Reports of the activities of this project were reported at the Pre-K ICC meetings and provided additional input to the committee. The involvement of representatives outside the child care industry was not received although repeated requests were made for individual participation from the diverse organizations. A list of the IAG Advisory Committee is attached.

Once the Advisory Committee was established the details of the contract were reviewed and input was gathered from the members. Specific activities of the committee began with the definition of minimum requirements for child care centers and family child care homes wishing to apply for funding. Parameters were developed for funding for equipment, supplies, and physical modifications. A great concern of the committee was the establishment of a process that would promote appropriate use of existing resources, both financial and service oriented before utilization of funds from this contract.

These initial recommendations were reviewed and approved by the DDC. The intent was to coordinate the services available among those participating on the advisory committee and the community at large, and then work to blend multiple funding sources. This pilot project was to assist at least 30 licensed child care settings throughout the county.

While the criteria and design of a formal application was being considered a request for letters of intent (see attached) was circulated county wide to child care providers. This was accomplished with the assistance of the central agencies, child care licensing, center based provider and family child care home provider organizations. The information received from this form ultimately was not sufficient but the response did serve as a database of interested providers. These providers were contacted and advised further information would be forthcoming.

Procedure

After several months of the project chair and one part-time member of the KIDCO staff, attempting to handle all the administrative responsibilities and the requests for information it was decided by the committee to hire a project manager. A job description (see attached) was drafted and circulated. Several resumes were received and the committee interviewed the most qualified applicants. The position was filled and work began with the project chair on a new action plan.

The first item on the plan was to design an application form that would provide sufficient detail about the center or home. The application needed to request information including but not limited to the following; the adult-child ratio and group size in the center, how long the staff had been employed, level of training and whether the staff had received inclusion training, were there children present with diagnosed special needs or disabilities and could the center meet the needs of these children. The application also needed to question what the funding would be used for- how would this expenditure better meet the needs of the children, and if the benefit would be sustained after the funds were depleted.

A draft application was presented to the committee and several issues were discussed. It was determined that in addition to the application form, a brief narrative and a budget of proposed expenditures should be part of the process. With the noted additional items included the application (see attached) was completed and sent to those centers or homes that had responded to the request for letters of intent. Additionally it was decided that the project manager would visit and evaluate all the centers and homes that submitted complete applications. This concept was a noble gesture, but was stopped after the on-site visits proved to be very time-consuming and not productive to the outcome of this grant.

Objective

The purpose of this grant was to increase the availability and supplement the services offered to children with special needs and disabilities by centers and homes. There were several lengthy debates during the committee meetings as to the manner in which we should qualify recipients. The level of quality was continually the topic, however there was no consensus on which instrument would provide a consistently valid measure of quality across all settings and not overburden the project manager. The evaluation instrument also needed to consider that the placement of the child was a parental choice. It was eventually determined our goal was not to assess the quality of child care centers or homes but to assist in the efforts to provide better care for children with special needs or disabilities in their care. We could monitor the use of the funds to assure optimal benefits were obtained, but not the parent's choice of care.

Letters of intent were received from 21 family child care homes and 42 child care centers in response to the initial call for proposals. From these 63 responses the total funding requested was $1,241,640 ranging from requests for no dollar figure given to $444,768.

In response to the request for further information and a proposed budget, a total of 20 applicants, 8 family child care homes and 12 child care centers responded. The total assistance requested was $189,742 with a range of zero to $50,000. Applications were received from a family child care home and two child care centers after the final determinations had been made. An invitation to resubmit was forwarded. A copy of the award letters, acceptance guidelines and invitation to reapply are attached.

Implementation

Funding for additional, temporary part-time, full-time, experienced or specially trained staff, teachers or counselors as well as major building renovations, instructional materials and indoor/outdoor equipment were received. Funds were not awarded for training or for hiring permanent personnel. Assistance was provided for substitutes to allow current staff to attend existing training, supplemental assistance, minor structural modifications, purchasing of instructional materials and indoor/outdoor equipment.

A total of $47,105 was distributed to 4 family child care homes ($3,789) and 9 child care centers ($43,316). A list of the grant recipients and description of the award received is attached. One center declined a $638 award due to program limitations. The unused balance totals $3,533 and was rolled over to the next year.

Outcomes

During this pilot year several issues became apparent that will need to be addressed before further awards are given. While most of the recipients forwarded their receipts of expenses promptly as indicated in the contract, receipts were not particularly indicative of the meeting the intention of this grant, and several recipients had to be asked repeatedly to submit receipts. Furthermore, it became obvious if the funds were given prior to the expenditure being made we had little ability to oversee the specific use of these funds or determine if the expenses were in line with the purpose of this grant. Reimbursing receipts for justified expenses or open purchase orders might limit this concern. Visiting the center before and after the funds are awarded to observe the proposed benefits or enhancement of services might also be instituted, providing adequate compensation and time for the project manager is allowed.

Another issue of concern was the overall misunderstanding of the term inclusion. While the criteria for the applicants were to have previously attended training in this area, it was noted attending training did not insure the comprehension of the concept. Furthermore a great many of the applications stated the need for further training, additional trained staff or indicated in general they were not comfortable with their ability to provide care for children with special needs or disabilities. In some instances the request for funding did not pertain to enhancing the quality of care for children with special needs or disabilities at all.

It was suggested by the advisory committee more training for the appropriate practice of inclusion and specific training for early intervention and adaptive activities for children with special needs should be available. Additionally the necessity of early intervention and special needs consultants to assist the centers and homes when the need for specific training is determined is obvious. Within the scope and resources of most child care centers and family child care homes the ability to meet the needs of the children who might require special assistance is not being met.

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FLORIDA DEVELOPMENTAL DISABILITIES COUNCIL, INC.

124 Marriott Drive, Suite 203, Tallahassee, Florida 32301-2981, (850) 488-4180, FAX (850) 922-6702, TDD (850) 488-0956

Exhibit A to FDDC Contract: 163CD98

Provider Name and Address:
KIDCO, Inc.
3630 NE 1st Ct
Miami, Florida 33137

Contract Period: November 1, 1998- September 30, 1999

Period Covered This Report: 9/1/99 to 9/30/99

SEE NOTE BELOW - RE: MATCH

Total Match	Match to Date	Remaining Match
$19,332.00		

Contracted Services				Service Delivered This Period	
Deliverable	Due Dates 98-99	#	Amount	#	$ Amount
Deliverable #1	November 1, 1998	1	$1,000.00	DCF	$6,250.00
Deliverable #2	December 1, 1998	1	$1,000.00	DCF	$6,250.00
Deliverable #3	February 1, 1999	1	$1,000.00	DCF	$6,250.00
Deliverable #4	March 1, 1999	1	$1,000.00	DCF	$6,250.00
Deliverable #5	May 1, 1999	1	$1,000.00	DCF	$6,250.00
Deliverable #6	June 1, 1999	1	$1,000.00	DCF	$6,250.00
Deliverable #7	August 1, 199	1	$1,000.00	DCF	$6,250.00
Deliverable #8	September 1, 1999	1	$1,000.00	DCF	$6,250.00
Total			$8,000.00		$50,000.00

PROVIDER CERTIFICATION: I certify that the above report is a true and correct reflection of this period's activities, and that the services deliverables related to the above referenced contract. Documentation supporting this report is on file in my office.

6/1/00
Signature of Provider Agency Official Date

[illegible] Executive Assistant
Typed or Printed Name and Title of Agency Official
Phone Number:

NOTE: Match provided through this contract is in the form of "in kind time."

For Florida Developmental Disabilities Council Use Only

Received at FDDC:________________

Deliverable Acceptable: ☐ Yes ☐ No

Programmatic Staff Signature/Date

Invoice Acceptable and Certified for Payment: ☐ Yes ☐ No

Grants and Contracts Manager Signature/Date

Data Entry	Payment
Account:	Check Number:
Amount:	Amount:
Date Entered:	Date Issued:
By:	By:

FDDC Form 98-01 of February 11, 1998

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INCLUSION ASSISTANCE GRANT
List of Advisory Committee Members

DR. CAROLE FOX ABBOTT

Florida Diagnostic and Learning Resources System-South (FDLRS-South)
5555 S.W. 93rd Avenue
Miami, Florida 33165

Phone # (305) 274-3501
Fax # (305) 598-7752

MIKE CONTE

District Supervisor Early Childhood Programs
Miami-Dade County Public Schools
1500 Biscayne Blvd. Room 335
Miami, Florida 33132

Office # (305) 995-7639
Fax # (305) 995-7650

VICKIE BURLEY

Director, Project Thrive
Association For Retarded Citizens (ARC)
5555 Biscayne Boulevard
Miami, Florida

Phone # (305) 759-8500
Fax # (305) 754-9223

DR. SILVIA LA VILLA

Chairperson, Pre-Kindergarten Early Intervention Interagency Coordinating Council
Executive Assistant, KIDCO Child Care Inc.
3630 N.E. 1st Court
Miami, Florida 33137

Office Phone # (305) 576-6990
Fax # (305) 576-5321
e-mail Kidco@shadow.net

DOLORES MENDOZA

Coordinator Prekindergarten Parent Education
Miami Dade County Public Schools Exceptional Student Education
Prekindergarten Program for Children with Disabilities
5555 S.W. 93rd Avenue Trailer # 1
Miami, Florida 33165

Office Phone # (305) 271-5701
Fax # (305) 598-5253

VALERIE WILKERSON

Education Specialist
Early Childhood Programs
Miami-Dade County Public Schools
1500 Biscayne Blvd. Room 335
Miami, Florida 33132

Office # (305) 995-7636
Fax # (305) 995-7650

Project Fiscal Coordinator

FRANK R. EMMERT

Fiscal Coordinator
KIDCO Child Care Inc.
3630 N.E. 1st Court
Miami, Florida 33137

Office Phone # (305) 576-6990
Fax # (305) 576-5321
e-mail kidco@shadow.net

Project Manager

MICHELE D. SCOTT, M.S.
13400 North Miami Avenue
Miami, Florida 33168

Office Phone # (305) 322-6059
Fax # (305) 681-1903
e-mail md_scott@bellsouth.net

Revised 03/22/99

January 20, 1999

Dear Center Directors:

We are excited to share with you the news that a grant has been awarded to Miami-Dade County from the Florida Developmental Disabilities Council and the Florida Department of Children and Families.

This grant will assist community childcare centers in serving children with special needs. Limited monies have been allocated for use by childcare centers to accommodate special needs children, birth through school age, in their programs.

In the past, studies have shown that childcare centers are willing to serve children with special needs but that they frequently require additional funds to realize program, facility and material modification.

If you are interested in applying for grant monies to assist you in serving children with disabilities in your child care center, please complete the enclosed form and return it by Friday February 12, 1999 to the address listed below. The Project Manager who will assist you with the full application process will contact you.

Sincerely,

Silvia La Villa, Ed. D.
Advisory Committee Chair

Mail form to: Attention Silvia La Villa, Ed. D.
KIDCO Child Care Inc.
3630 N.E. 1st Court
Miami, Florida 33137

Phone: (305) 576-6990
Fax: (305) 576-5321
Email: kidco@shadow.net

RECEIVED FEB 03 1999

FLORIDA DEVELOPMENTAL DISABILITIES COUNCIL – GRANT
Miami-Dade County
INTENT FORM

Name of Center: ____________________

Contact Person: ____________________

Address: ____________________

Phone: ____________ Fax: ____________ Email: ____________

Briefly state why you want to apply for grant funds and how those funds would be utilized, if awarded. Also list any questions you may have regarding these grant funds.

Amount of grant money you may wish to apply for $____________

Please return this form by Friday February 12, 1999 to:
Silvia La Villa, KIDCO Child Care Inc. 3630 N.E. 1st Court Miami, Florida 33137

Inclusion Assistance Grant
Florida Developmental Disabilities Council
Miami-Dade County

February 12, 1999

Dear Family Child Care Provider.

We are excited to share with you the news that a grant has been awarded to Miami-Dade County from the Florida Developmental Disabilities Council and the Florida Department of Children and Families.

This grant will assist our community child care centers and homes in serving children with special needs. Limited monies have been allocated for use by child care providers to accommodate special needs children, birth through school age, in their programs.

In the past, studies have shown that child care providers are willing to serve children with special needs but that they frequently require additional funds to realize program, facility and material modification.

If you are interested in applying for grant monies to assist you in serving children with disabilities in your family child care home, please complete the enclosed intent form and return it by February 26, 1999, to the address listed below. The project manager who will assist you with the full application process, will contact you.

Sincerely,

McGrath for
Silvia La Villa, Ed. D.
Advisory Committee Chair

Mail form to: Attention - Silvia La Villa, Ed.D.
KIDCO Child Care Inc,
3630 N.E. 1st Court
Miami, Florida 33137

Phone: (305) 576-6990
Fax: (305) 576-5321
Email: kidco@shadow.net

Inclusion Assistance Grant
Florida Developmental Disabilities Council
Miami-Dade County

INTENT FORM

Name of Family Child Care Provider : ______________________

Address: ______________________

Phone: __________ Fax: __________ Email: __________

Briefly state why you want to apply for grant funds and how those funds would be utilized, if awarded. Also list any questions you may have regarding these grant funds.

Amount of grant money you may wish to apply for $__________

Mail form to: Attention - Silvia La Villa, Ed.D.
KIDCO Child Care Inc,
3630 N.E. 1st Court
Miami, Florida 33137

Phone: (305) 576-6990
Fax: (305) 576-5321
Email: kidco@shadow.net

PART TIME JOB OPPORTUNITY

Here is an opportunity to join an initiative in Dade County that will make a difference in the lives of children with special needs. Interested candidates for this part-time position needs to have a background in the area of special education and preferably experience.

KIDCO Child Care Inc. is the acting fiscal agent for funding awarded by the Developmental Disabilities Council and the Florida Department of Children and Families. This initiative will help us identify barriers that today keep our young special needs children out of childcare programs.

JOB DESCRIPTION FOR PROJECT MANAGER

Work up to 15 hours per week – maximum number of hours 460 – earning up to $7,000.00 as Project Manager

Responsibilities include:

- Help write project's action plan
- Help develop application process
- Help establish project criteria
- Share responsibilities for report writing, paper work, etc with KIDCO staff
- Monitor RFP Process
- Make recommendations to the advisory committee
- Assist with raising public awareness of the project
- Site visits to centers being considered by advisory committee
- Follow up with grant recipients
- Work directly with persons collecting data for accountability purposes
- Report to Advisory committee and work directly with DD Council, representatives of the fiscal agent KIDCO Child Care Inc.

Any interested persons should call Dr. Silvia La Villa at (305) 576-6990

FLORIDA
DEVELOPMENTAL
DISABILITIES
COUNCIL, INC.

Inclusion Assistance Grant Application for Miami-Dade County

Greetings!

The following information is being sent as a follow up to your letter of intent for funding from the Inclusion Assistance Grant.

Please read the enclosed information carefully and complete the application as accurately as possible. The Advisory Committee will be considering the information you provide with this application along with a site-visit in their awarding of funding. Special consideration will be given to those applicants who have already received special needs training for their staff or those who are currently working with children with special needs or disabilities.

The total available funding for this year is $50,000 for disbursal among childcare providers in Miami-Dade County demonstrating a desire to improve the services available to children with special needs. One of the primary objectives of this initiative is to assist with linking of existing services in our community with childcare providers caring for children with special needs who may not be aware of the availability of these services.

Please mail or fax the completed application, budget detail and narrative to the address indicated on the bottom of the form.

If you have any further questions or concerns you may call the project manager, Michele Scott at 305 322-6059.

FLORIDA
DEVELOPMENTAL
DISABILITIES
COUNCIL, INC.

Inclusion Assistance Grant Application for Miami-Dade County

Name of Child Care Center or Home	Date: Phone:
Name of Contact Person: Center Director or FCC Operator	Fax: License # (Provisional?)

Address	City/State	Zip code

Staff Composition (specifiy number of persons in each category) Family Child Care Provider

Center Director	Assistant Director	Curriculum Specialist	Lead Teacher	Teacher	Teacher Assistant	Teacher Aide

Other Staff (please specify)	Other (please specify)	Other (please specify)

Hours of Operation

Weekdays: Monday - Friday	Evenings: after 6 pm	Weekends: Saturday	Sunday	Total Hours of Operation Per Week

Is your Center currently accredited? If yes, by whom?

Yes No In process/applied

Enrollment Composition (please specify number of children)

0 to 12 mths	13 to 24 mths	2 years old	3 years old	4 years old	4-5 yrs old (Pre-K)	School-age Program Before After School

Other Ages (please specify)	Total Enrollment	Estimate of the number of families served by your center:

Ethnic composition (please specify number of children)

African American:	Hispanic:	Haitian/Haitian American:	Native American:	Asian/Pacific Islander:	Non-Hispanic White:

Does your facility accept children with:	How many children currently enrolled:
known disabilities?	have a diagnosed disability?
special needs?	are suspected of having a disability or special need?
not toilet trained?	

Does the center have a procedure or policy for identifying children with disabilities

What is the position of the person who is responsible for identifying the children?

What is the position of the person who is responsible for talking with the parents?

Is there referral information available for parents and families?

Does anyone at the center administer tests or measures to screen children for developmental delays?

If yes, which screening instruments or measures are used?

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Briefly describe how the staff would (does) work with children who are at-risk for developmental delays?

Briefly describe how the staff would (does) work with a child with special needs (a disability)?

Are any of the staff licensed or certified or have any special training in Early Childhood Special Education? (list name of staff, position and credential or training)

What barriers, if any, have interfered with including children with special needs into the program?

What amount of money would assist the center in serving children with disabilities?

Briefly explain why the current budget does not allow for provision of the requested service / expenditure.

Provide a detailed narrative (no more than five pages) of how this money would be used. Include a proposed budget for the funds requested (see attached form), any information related to how these funds would be used for a specific child (or children) with a disability already attending, and a description of the center's commitment to actively seek and include children with disabilities.

Completion of this form should be viewed only as information gathering for advisory committee review. It does not imply any commitment to award funding to this center or program nor does it imply selection for further participation. Thank you.

Within the next 10 days please complete and return by MAIL or FAX to:

Inclusion Assistance Grant
KIDCO CHILD CARE, INC
3630 NE 1st Court
Miami, FL 33137

phone (305) 576-6990
fax (305) 576-5321

Signing this application certifies that the responses are true and accurate to the best of my knowledge.

X

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Proposed Budget for Inclusion Assistance Grant

Site/Center/Home:

Expenditures	Current Budget	Proposed Budget
Teacher Salary		
Paraprofessional Salary		
Substitutes		
Instructional Materials		
Indoor / Outdoor Equipment		
Building Renovation or Structural Modification		
Other		
Total Expended		
Total Requested		

Comments:

FLORIDA DEVELOPMENTAL DISABILITIES COUNCIL
Inclusion Assistance Grant
KIDCO Child Care, Inc.
3628 N.E. 1st Court
Miami, Florida 33137
(305) 576-6990

June 15, 1999

Director
Center
Address
Miami, FL

Dear ,

Thank you for submitting your proposal for the Miami-Dade County Inclusion Assistance Grant. The Advisory Committee recently met to review the applications received and to consider the requests for funding. There were many worthy requests and considerable effort was made to distribute the limited funds as fairly as possible. It was a challenge to have to decide which proposals would be funded.

The Advisory Committee considered the proposed budget submitted with your application and has awarded the *Name of Center* $0,000 for the purchase of *purchase/expense as per proposal*. The following page details the guidelines for receiving this award.

Should you have any further questions or concerns, please contact Dr. Silvia LaVilla, Project Chair at KIDCO Child Care or Michele Scott, Project Manager at 305 322-6059.

Your effort to enhance the quality of child care in Miami-Dade County for children with special needs is to be commended.

Sincerely,

Silvia La Villa, Ph.D.

SLV/mds

FLORIDA DEVELOPMENTAL DISABILITIES COUNCIL

Inclusion Assistance Grant

KIDCO Child Care, Inc.
3628 N.E. 1st Court
Miami, Florida 33137
(305) 576-6990

Grant Acceptance Guidelines

The awarding of the Inclusion Assistance Grant to Miami-Dade County came with the specific requirement that the funding be used strictly for the purpose intended; to improve the availability and quality of the choices of care for children with special needs and disabilities. The expenses and purchases by the grant recipients should demonstrate an effort to provide a more inclusive environment for young children and meet the following terms and conditions.

1) With regard to any structural modification or addition, please seek information regarding permits from local building and zoning departments. Be advised, there are certain specifications detailed by the Americans with Disabilities Act regarding the construction of ramps and remodeling child care facilities. Written guidelines should be obtained by calling the ADA hotline at 1-800-514-0301.

2) An itemization of all expenses and purchases with supporting documentation (contracts or receipts) must be provided to KIDCO at the address listed above by September 20, 1999. Any part of the grant designated for materials or equipment not expended shall be returned to the Advisory Committee. Should assistance with suppliers or manufacturers of materials or equipment be necessary, please contact the project manager.

3) The documentation for hiring of additional personnel should provide substantial employee information including name, qualifications, social security number, weekly schedule and hourly rate. An interim report to the Advisory Committee must be received by September 20, 1999 and include signed time sheets to date, the balance of funding remaining and the projected ending date. A final report should be sent summarizing the total expenditure of the grant after this date.

ACCEPTED AND AGREED:

Business Name: ______________________________
Please print

Authorized by: ______________________________
Please print

Signature: ______________________________

Date: ______________________________

Grant funds will be sent by certified mail to the address on file upon receipt of signed grant acceptance guidelines

FLORIDA DEVELOPMENTAL DISABILITIES COUNCIL
Inclusion Assistance Grant
KIDCO Child Care, Inc.
3628 N.E. 1st Court
Miami, Florida 33137
(305) 576-6990

June 15, 1999

Name
Business
Address
City

Dear Applicant,

Thank you for submitting your proposal for the Miami-Dade County Inclusion Assistance Grant. The Advisory Committee recently met to review the applications received and to consider the requests for funding. There were many worthy requests and considerable effort was made to distribute the limited funds as fairly as possible. It was a challenge to have to decide which proposals would be funded. While we could not offer your program assistance this year, there will be money available next year and you are welcome to submit another application at that time.

The Advisory Committee considered the proposals based on specific criteria as set forth by the Florida Developmental Disabilities Council. Centers or family child care homes where children with diagnosed special needs were already attending and where staff had already received inclusion or special needs training received primary consideration. The availability of other sources of funding was also considered, as was the ability to sustain the effort past the initial grant.

Please contact Project Manager, Michele Scott at 305 322-6059, should you need information regarding the availability of inclusion training or referral information for children currently in your care. Should you have any further questions or concerns regarding award determination, please contact Dr. Silvia LaVilla, Project Chair at KIDCO Child Care.

Your desire to enhance the quality of child care in Miami-Dade County for children with special needs is to be commended.

Sincerely,

Silvia La Villa, Ph.D.

SLV/mds

Child CareCenter	Award	Primary Improvement
Allapattah YMCA	$7,000	Instructional materials and indoor/outdoor equipment
Catholic Charities: Centro Mater & Centro Mater West	$5,000	Instructional materials and indoor/outdoor equipment
Family Center	$8,700	Building renovations, part-time staff & instructional supplies
North Dade Child Development Center	$6,306	Instructional materials and indoor/outdoor equipment
O'Farrill Learning Center	$1,000	Instructional materials
Paradise Christian	$8,000	Instructional materials and indoor/outdoor equipment
Redlands Christian Migrant Association	$ 600	Instructional materials and indoor/outdoor equipment
United Cerebral Palsy of Miami	$ 638	Declined award
West Dade YMCA	$6,080	Part-time staff, after school program, summer camp
Family Child Care		
Doralia Cervantes	$ 500	Instructional materials and indoor/outdoor equipment
Carmen Garcia	$1,000	Structural modifications and indoor equipment
Clara Moore	$1,289	Indoor/outdoor equipment
Dornetha Warren	$1,000	Structural modifications and indoor /outdoor equipment

Agreement to provide services as a

Special Instruction Consultant

for the **Florida Developmental Disabilities Council Inclusion Assistance Grant** to the **Miami-Dade County School Readiness Coalition.**

The below named applicant has met the educational and experience requirements to participate as a Special Instruction Consultant (SIC) as described by the requirements set forth by the Inclusion Assistance Grant (IAG) Advisory Committee.

This agreement is in effect from the date signed until terminated by either the SIC or the Miami-Dade County School Readiness Coalition upon recommendation from the IAG Advisory Committee.

This position is for a part-time consultant, with no benefits or travel allowance provided.

As part of my employment with the Miami-Dade County School Readiness Coalition I agree to submit to certain specific drug screening tests. I understand should the tests indicate positive results, my employment will not be possible until such time as negative results have been obtained.

I agree to participate as a SIC according to the guidelines developed by the IAG Advisory Committee described herein and with any subsequent amendment as set forth by this committee.

Name of SIC: ______________________________ Signature: ____________________________

Project Manager: _________________________Signature: ____________________________

For Miami-Dade County School Readiness Coalition: Signature: _________________________

Date: ____________________________

factors related to growth and development of children birth through age 5 with established or suspected conditions and/or developmental disabilities. This will include one-on-one work with individual staff, and the provision of resource materials and, when appropriate, model teaching with the targeted child.

6. The consultant may coordinate with the FSP team, the family, the classroom teacher, and others as appropriate to develop for each child from birth to five years of age, goals and assist in implementing strategies to accomplish those goals within the curriculum used by the early care and education center or family child care home.

7. The Special Instruction Consultant will document and maintain records, as will be provided, of all direct contact and activities with the early care and education center staff or family child care provider. These records will be forwarded to the project manager on a monthly basis.

FLORIDA DEVELOPMENTAL DISABILITIES COUNCIL
Inclusion Assistance Grant
Miami-Dade County School Readiness Coalition
3250 SW Third Ave/Fifth Floor
Miami, FL 33129
(305) 646-7220

Servicios de Asesoria en Instrucción Especial.

Los Servicios de Asesoria en Instrucción Especial hacen parte de un programa que provee asistencia a educadores por medio de observaciones, soporte, y nuevas ideas para los centros de educación preescolar mediante aportes del Florida Developmental Disabilities Council. Deseamos que nos permitan observar a su hijo o hija y así poder adaptar y modificar nuestro ambiente educativo a las necesidades individuales de el / ella. Estos servicios son SIN COSTO ALGUNO. Gracias por permitirnos mejorar el cuidado de su hijo / hija.

Por favor marque la casilla correspondiente:

____ **Si** doy consentimiento para que mi hijo / hija sea observado por Asesores en Instrucción Especial para ayudarles en sus necesidades individuales.

____ **No** doy consentimiento para que mi hijo / hija sea observado por Asesores en Instrucción Especial para ayudarles en sus necesidades individuales.

Nombre del niño/niña	Fecha de nacimiento
Nombre del padre/guardian	Fecha
Nombre del Centro Educativo	Dirección

Nombre del Educador	Posición	Telefono / Fax

Para mas información o citas llame a:

Bethany Sands
(305) 646-7221
o
Carola Matera
(305) 646-7224

FLORIDA DEVELOPMENTAL DISABILITIES COUNCIL

Inclusion Assistance Grant

Miami-Dade County School Readiness Coalition

3250 SW Third Ave/Fifth Floor
Miami, Florida 33129

Special Instruction Consultant Services

The Special Instruction Consultant Service is a program that assists childcare providers by observing and offering support and new ideas for the early care and education center or family child care home through a grant from the Florida Developmental Disabilities Council. We would like your permission for a Special Instruction Consultant to observe your child and help us adapt and modify our environment to meet the individual needs of your child. Theses services are offered at NO charge. Thank you for allowing us to better care for your child.

Please check one:

_____ **I do** give permission for my child to be observed by the Special Instruction Consultant to assist with meeting this/her needs.

_____ **I do not** give permission for my child to be observed by the Special Instruction Consultant to assist with meeting his/her needs.

Child's Name ____ DOB ____ Parent/Guardian Signature ____ Date ____

Child Care Center ____ Address ____

Child Care Center Professional ____ Title ____ Telephone/fax ____

For further information or to speak with a Special Instruction Consultant call:

Bethany Sands
305-646-7221
or
Carola Matera
305-646-7224

Directions for Completing Table A and B:

- Place the number of children in the correct age column indicating the appropriate condition.
- Select the primary condition when multiple ones exist.
- Do not include children whose only special need is unmanageable behavior, wearing eye glasses, allergies or mild medical conditions that do not require any special attention. Also, do not include children whose only special need is learning English as a second language.

Table A- In this table you should include children in your care who have formally diagnosed and/or confirmed conditions through such avenues as the medical specialist, pediatrician, clinic or disability related program. This can be conveyed either directly by these entities or through the families.

Diagnosed	**NUMBER OF CHILDREN IN THE FOLLOWING AGE GROUPS:**								
	Under 1 Year Old	1 Year Old	2 Years Old	3 Years Old	4 Years Old	5 Years Old (not Kinder garten)	Elementary School Age	Middle School Age	Total Number of Children
An obvious physical or mental disability or delay.									
A medical condition that requires some special attention (e.g., [illegible]ng tube, special medications).									
A developmental delay									
A significant vision or hearing impairment.									
Serious behavioral disorders.									
Speech and language delay or impairment.									
Seizure disorders									
ADHD/ADD									
Autism									
Cystic Fibrosis									
Diabetes									
Severe allergies									
Severe asthma									
Other									
Other									
Other									

Table B – In this table you should include children in your care who have a suspected condition but which has not been formally diagnosed or confirmed.

Suspected	NUMBER OF CHILDREN IN THE FOLLOWING AGE GROUPS:								
	Under 1 Year Old	1 Year Old	2 Years Old	3 Years Old	4 Years Old	5 Years Old (not Kinder - garten)	Elementary School Age	Middle School Age	Total Number of Children
An obvious physical or mental disability or delay.									
A medical condition that requires some special attention (e.g., feeding tube, special medications).									
A developmental delay									
A significant vision or hearing impairment.									
Serious behavioral disorders.									
Speech and language delay or impairment.									
[illegible]re Disorders									
[illegible]HD/ADD									
Autism									
Cystic Fibrosis									
Diabetes									
Severe allergies									
Severe asthma									
Other									
Other									
Other									

IV. For any of the children with disabilities or special health care needs you identified in Table A or B, are you:

	YES	NO
• Utilizing any special service or support to address their specific needs.	____	____
• Somehow informed or linked into the children's service system to meet their disability or special health care needs.	____	____

If yes, please identify below:

1 Special Services or Supports

____ Therapy Services in Center
____ Therapy Services provided outside the center (Special Instruction Consultant)
____ Part H/C Service: Consultative Model Used
____ Special Equipment
____ Special Instruction provided by the School System
____ Other – Please Identify ______________________________

FLORIDA DEVELOPMENTAL DISABILITIES COUNCIL, INC.

Inclusion Assistance Grant for Miami-Dade County

Name of Child Care Center or Home	Date:
	Phone:
Name of Contact Person: Center Director or FCC Operator	Fax:
	License # (Provisional?)

Address	City/State	Zip code

Staff Composition (specifiy number of persons in each category) Family Child Care Provider

Center Director	Assistant Director	Curriculum Specialist	Lead Teacher	Teacher	Teacher Assistant	Teacher Aide

Other Staff (please specify)	Other (please specify)	Other (please specify)

Hours of Operation

Weekdays: Monday - Friday	Evenings: after 6 pm	Weekends: Saturday	Sunday	Total Hours of Operation Per Week

Is your Center currently accredited? If yes, by whom?

Yes No In process/applied

Enrollment Composition (please specify number of children)

0 to 12 mths	13 to 24 mths	2 years old	3 years old	4 years old	4-5 yrs old (Pre-K)	School-age Program Before After School

Other Ages (please specify)	Total Enrollment	Estimate of the number of families served by your center:

Ethnic composition (please specify number of children)

African American:	Hispanic:	Haitian/Haitian American:	Native American:	Asian/Pacific Islander:	Non-Hispanic White:

Does your facility accept children with:	How many children currently enrolled:
known disabilities?	have a diagnosed disability?
special needs?	are suspected of having a disability or special need?
not toilet trained?	

Does the center have a procedure or policy for identifying children with disabilities

What is the position of the person who is responsible for identifying the children?

What is the position of the person who is responsible for talking with the parents?

Is there referral information available for parents and families?

Does anyone at the center administer tests or measures to screen children for developmental delays?

If yes, which screening instruments or measures are used?

BEST COPY AVAILABLE

Briefly describe how the staff or provider works with children who are at-risk for developmental delays?

Briefly describe how the staff or provider works with a child with special needs (a disability)?

Are any of the staff licensed or certified or have any special training in Early Childhood Special Education? (list name of staff, position and credential or training)

What barriers, if any, have interfered with including children with special needs into the program?

BEST COPY AVAILABLE

To:

From
FLORIDA DEVELOPMENTAL DISABILITIES COUNCIL
Inclusion Assistance Grant
Miami-Dade County School Readiness Coalition

Special Instruction Consultant

Date:

Signed:

FLORIDA DEVELOPMENTAL DISABILITIES COUNCIL

Inclusion Assistance Grant

Miami-Dade County School Readiness Coalition

Special Instruction Consultant Participation Agreement

The child care center or family child care home referenced below agrees to participate in the Inclusion Assistant Grant Special Instruction Consultant program. This program is design to offer at no cost, instructional assistance for early care and education teachers who are working with children diagnosed or suspected of having special needs or developmental delays. Funding will be provided for the Special Instruction Consultant by a grant received from the Florida Developmental Disabilities Council administered through the Miami-Dade County School Readiness Coalition.

Conditions of this agreement are as follows:

1. Maintain a current Dept of Children and Families certificate according to F.A.C. 65C-20 or 65C-22 and be in good standing with the licensing department.
2. Arrange time for staff to work with the Special Instruction Consultant.
3. Implement program plans developed with the Special Instruction Consultant for children with special needs.
4. Participate in an satisfaction survey of the staff and the families of children enrolled in the child care center or family child care home diagnosed or suspected of having special needs or developmental delays receiving the Special Instruction Consultant services.
5. Allow therapists and /or early intervention providers to work with children enrolled in the child care center or family child care home diagnosed with special needs or developmental delays when specified on the child's Family Support Plan or Individual Education Plan.
6. Provide information and participate in the Family Support Planning or Individual Education Plan process for children enrolled diagnosed with special needs or developmental delays served in the child care center or family child care home.
7. Participate in or assist with interagency coordination efforts. Participation may include participation at meetings, subscribing/reading minutes from such meetings, reviewing issues to be presented to such groups, and providing input on a timely basis into planning processes.
8. Have a written policy on the confidentiality of the records of staff and children that ensures that the facility or home will not disclose material child and personnel records without written consent from the parent/guardian and will adhere to procedural safeguard requirements for CMS Early Intervention Program or other authorized agency.
9. Implement an individual special instruction plan that is consistent with the Family Support Plan or Individual Education Plan. The initial plan is developed jointly by the early care and education teacher, the family, and others involved in the provision of services for the child (e.g., therapists). The plan addresses the needs of the child and the specific activities to address those needs which will be used during the child's participation in the child care program. Updates of the individual special instruction plan are developed with input from the individuals in the initial plan.
10. This agreement will be in effect from the date signed until terminated by the child care center or family child care home care provider or the Inclusion Assistance Grant Advisory Committee.

Child Care Center / Family Child Care Home ______________________________

Owner / Operator / Director ______________________________

Signature ______________________________ Date ______________

To: ____________________
____
____
____

From
FLORIDA DEVELOPMENTAL DISABILITIES COUNCIL
Inclusion Assistance Grant
Miami-Dade County School Readiness Coalition

Special Instruction Consultant ____________________

Date: ____________________

1. Observation/Component:

☐ learning environment
☐ daily routine
☐ greeting/morning circle
☐ plan/do/review
☐ large group
☐ small group
☐ communication
☐ outside
☐ transitions
☐ adult/adult
☐ adult/child
☐ discipline/behavior management
☐ assessment
☐ key note documentation
☐ lesson plans
☐ technology
☐ parent involvement
☐ child ____________________
☐ other ____________________

Comment: ____________________
____

2. Meeting:

☐ teacher/paraprofessional
☐ administrator
☐ school staff
☐ program
☐ parent
☐ networking
☐ workshop
☐ observation follow-up
☐ registrar/data input
☐ transportation
☐ needs assessment
☐ materials/equipment

Comment: ____________________
____

3. ☐ Check records

4. ☐ Delivery/pick-up

5. ☐ Resource materials

6. ☐ Comments/Recommendations
____
____

Next visit: ____________________

FLORIDA DEVELOPMENTAL DISABILITIES COUNCIL

Inclusion Assistance Grant

Miami-Dade County School Readiness Coalition

3250 SW Third Ave/Fifth Floor
Miami, Fl 33129 305-646-7220

Announces the availability of

Special Instruction Consultant Services

This program is made possible through a grant from the Florida Developmental Disabilities Council. Our Special Instruction Consultants will visit your early care and education centers or family child care home and provide the following services, at no charge:

Observation and Feedback- With parental consent, we will observe children in your care and answer questions or concerns you may have about their development.

Classroom Strategies- If you are unsure about how to address the individual needs of children, we can help you develop strategies or assist in curriculum implementation. If the student has an FSP or IEP, we will be able to provide guidance to your staff.

Families as Partners- We will help prepare your staff for parent meetings and work with you to develop effective partnerships as you provide information and support to families. We will participate in meetings as per your request.

Service Linkage- We will provide information about the therapists' roles, responsibilities and how to link therapy goals into classroom routines and activities.

Training- We will help you create programs and services that coordinate with child care regulations, the Americans with Disabilities Act (ADA), and the Individuals with Disabilities Education Act (IDEA). Staff workshops both informational and hands-on can be conducted at times convenient to your schedule.

Information and Referral- We can provide a list of other resources and services available for children with special needs and their families and can assist you in the referral process.

For further information and to schedule an appointment please call:
Bethany Sands
(305) 646-7221
or
Carola Matera
(305) 646-7224

FLORIDA DEVELOPMENTAL DISABILITIES COUNCIL
Inclusion Assistance Grant
Miami-Dade County School Readiness Coalition
3250 SW Third Ave/Fifth Floor
Miami, FL 33129
(305) 646-7220

Anuncia la disponibilidad de los ***Servicios de Asesoría en Instrucción Especial.***

Este programa es posible por medio de un aporte del Florida Developmental Disabilities Council. Nuestros Asesores en Instrucción Especial visitaran sus centros de educación y proveerán los siguientes servicios sin costo alguno:

Observación y Recomendación: Con permiso de los padres, observaremos a los niños en su cuidado y responderemos cualquier pregunta o preocupación que puedan tener acerca de su desarrollo.

Estrategias en el Aula: Si tienen alguna inseguridad acerca de cómo manejar las necesidades individuales de los niños, les podremos ayudar a desarrollar estrategias o asistirlos en la implementación de **FSP** o **IEP**.

Trabajo en Familia: Les ayudaremos a preparar reuniones de padres de hijos con necesidades especiales y trabajaremos con ustedes para crear una unión efectiva. Al mismo tiempo, podemos proveerles con la información y el soporte que tanto necesitan y participaremos en las reuniones si así lo requieren.

Servicio de Unión: Les proveeremos información y trataremos de unificar las terapias con las actividades en clase.

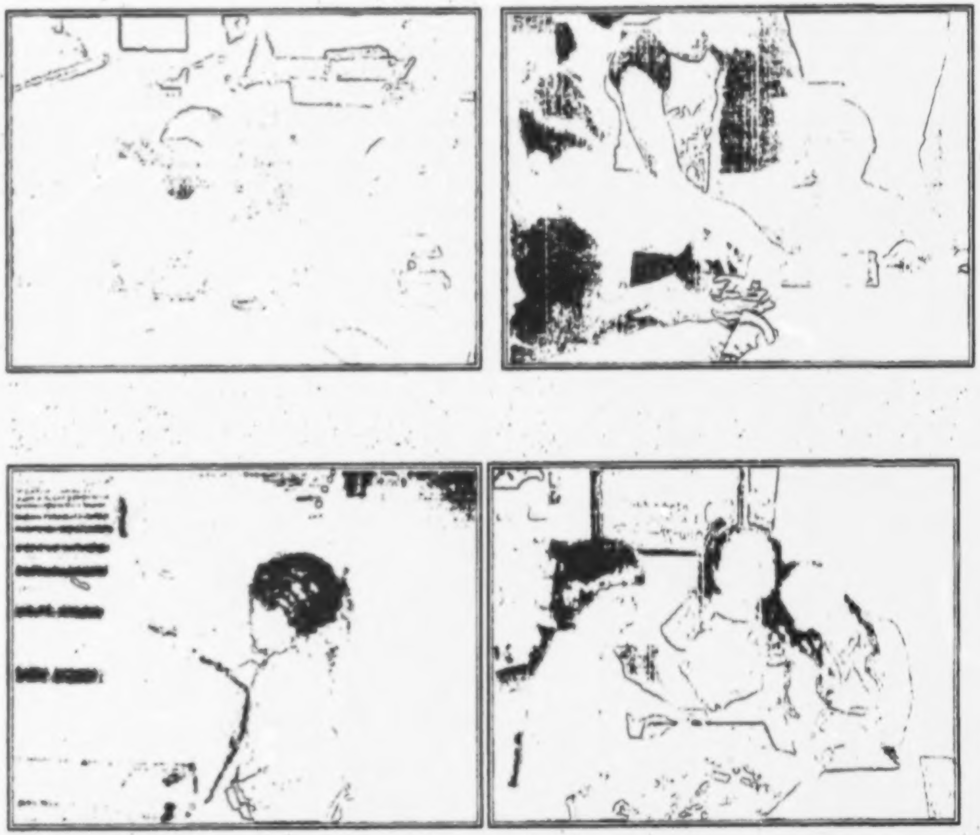
Entrenamiento: Les ayudaremos a crear programas y servicios que coordinen las regulaciones del cuidado de niños, el American with Disabilities Act (ADA), y el Individual with Disabilities Education Act (IDEA). Talleres para maestras tanto informativos como prácticos podrían ser organizados a su conveniencia.

Información y Referidos: Proveeremos una lista de recursos y servicios disponibles para niños con necesidades especiales y sus familias. Podremos también ayudar en el proceso de identificación y referidos a los servicios correspondientes.

Para mas información o citas llame a:

Bethany Sands
(305) 646-7221
o
Carola Matera
(305) 646-7224

Broward Inclusion Child Care Project



"Keys to Inclusion"
ESE INCLUSION

YMCA
We build strong kids,
strong families, strong communities

Summer Camp 2002 Outcomes

100% of children will not experience a serious injury (requiring emergency room attention), abuse or arrest while in care during the contract period.	**284 of 288**	**99%**
90% of children served will maintain placement in the home or least restrictive environment, and families served will experience relief from stress.	**278 of 288**	**97%**
85% of children served will increase social interaction/ participation with other children or adults: increase transition from activity and/or location; increase socially acceptable behavior; or decrease socially maladaptive behavior.	**272 of 288**	**94%**
90% of the children will receive at least one hour of silent and aloud reading each day.	**274 of 288**	**95%**

EXHIBIT F-1
OUTCOME REPORT

Agency Name: **YMCA of Broward County** Contract Number: **02-8269-CSAD-1** Year: **2002**

Quarter (Check One): (Oct. 1 – Dec. 31) ☐ (Jan. 1 – Mar. 31) ☐ (Apr. 1 – Jun. 30) ■ (Jul. 1 – Sep. 30) ☐

Service Description **After School & Extended Care for Children with Special Needs**

1. Performance Indicator: **90% of parents/guardians will be employed or enrolled in job training/education programs.**

Quarter (Can be duplicated between quarters)				Cumulative Fiscal Year-to-Date (must be unduplicated)			
# of Clients Served	# of Clients Evaluated	# of Clients Achieving Indicators	Percent [(3) divided by (2)]	# of Clients Served	# of Clients Evaluated	# of Clients Achieving Indicators	Percent [(7) divided by (6)]
(1) **276**	(2) **192**	(3) **181**	(4) **94%**	(5) **335**	(6) **335**	(7) **329**	(8) **98%**

2. Performance Indicator: **80% of children attending at least 3 months will demonstrate improvement in one or more of the following areas by the end of the school year: increasing social interaction with other children, increasing appropriate interaction with adults, demonstrating appropriate transition from activity and/or location, demonstrating socially acceptable behavior.**

Quarter (Can be duplicated between quarters)				Cumulative Fiscal Year-to-Date (must be unduplicated)			
# of Clients Served	# of Clients Evaluated	# of Clients Achieving Indicators	Percent [(3) divided by (2)]	# of Clients Served	# of Clients Evaluated	# of Clients Achieving Indicators	Percent [(7) divided by (6)]
(1) **276**	(2) **168**	(3) **146**	(4) **87%**	(5) **335**	(6) **300**	(7) **285**	(8) **86%**

3. Performance Indicator: **By the end of the current school year, a minimum of 50% of the students who were enrolled in the prior year program will maintain the goal achieved the previous year.**

Quarter (Can be duplicated between quarters)				Cumulative Fiscal Year-to-Date (must be unduplicated)			
# of Clients Served	# of Clients Evaluated	# of Clients Achieving Indicators	Percent [(3) divided by (2)]	# of Clients Served	# of Clients Evaluated	# of Clients Achieving Indicators	Percent [(7) divided by (6)]
(1) **276**	(2) **106**	(3) **100**	(4) **94%**	(5) **335**	(6) **106**	(7) **100**	(8) **94%**

Continue on additional sheets, if necessary.

Attach a narrative listing the barriers experienced in outcome achievement and any noteworthy activities that have occurred during this quarter. Also include a brief narrative explanation for each performance indicator Percent [(4) and/or (8)] that is 5 or more percrentage points below the contractually required level.

Prepared By:________ Authorized Signature:________ Title:________ Date:________

EXHIBIT F-2
CLIENT DEMOGRAPHIC DATA REPORT

Agency Name: **YMCA of Broward County** Year: **2001-2002**

Quarter (Check One): (Oct. 1 - Dec 31) ☐ (Jan. 1 - Mar. 31) ☐ (Apr. 1 - Jun. 30) ■ (Jul. 1 - Sep. 30)

Program Name: **After School & Extended Care for Children with Special Needs** Contract Number: **02-8269-CSAI**

CHECK ONE ■ Agency Records ☐ Estimate ☐ Other (Identify)

a. Number of clients enrolled at the beginning of the quarter for this Agreement	**276**	
b. Number of new clients in this quarter	**29**	
c. Number of clients served in this quarter	**305**	(a + b)
d. Number of clients terminated in this quarter	**9**	
e. Number of clients at the end of the quarter	**296**	(a + b - d)
f. Total number of unduplicated clients served, year-to-date for this Agreement	**335**	

Total Clients Served Year to Date for This Agreement

AGE	■	0-5		6-10		11-13		14-15		16-17		18-19		20-21		21+		TOTAL		TOTAL	Poverty
AGE	☐	0-17		18-21		22-49		50-59		60 +								(All Ages)		A + S	< Level
SEX		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M + F	
1. African American		21	11	24	14	23	21	13	8	10	1	3	1					94	56	150	
2. American Indian		1																1	0	1	
3. Black Hispanic				3													1	3	1	4	
4. White Hispanic		3		15	1	6		1		1			1		1			26	3	29	
5. Asian Indian																		0	0	0	
6. Other Asian																		0	0	0	
7. Haitian		1		1														2	0	2	
8. Other		3		3	1	1		1			1							8	2	10	
9. White		5	3	32	20	18	5	8	5	15	3	5	1	6	1	5	7	94	45	139	
10. Total		34	14	78	36	48	26	23	13	26	5	8	3	6	2	5	8	228	107	335	

Advisory Board

A.R.C. Broward
Broward Chapter / Autism Society of America
Broward County Parks & Recreation
Center for Independent Living
Children's Services Administration Division
Children's Services Council
City of Fort Lauderdale
Coordinating Council of Broward County
Dan Marino Foundation
Family Central, Inc.
Florida Developmental Disabilities Council
Gold Coast Down Syndrome Organization
Henderson Mental Health Center
Nova Southeastern University
School Board of Broward County
Before & After School Department
Exceptional Student Education Department
Florida Diagnostic & Learning Resources System
Department of Student Activities & Affairs
United Cerebral Palsy
United Way of Broward County
YMCA of Broward County

SUpPORTeRS

Broward Chapter
Autism Society of America

Broward County
Board of County Commissioners

Broward County Sheriff's Office

Children's Services Council

Community Foundation of Broward

Florida Department of Children & Families

Florida Developmental Disabilities Council

School Board of Broward County

United Way of Broward County

Locations

Coral Springs:
Coral Park Elementary
Cypress Park Recreation Center
(Teens and Adults)
Maplewood Elementary
Sawgrass Middle

Ft. Lauderdale:
Larkdale Elementary
Meadowbrook Elementary
North Fork Elementary
Rock Island Elementary
Westwood Heights Elementary
Wingate Oaks Center
(Teens and Adults)

Hollywood:
Bethune Elementary
Colbert Elementary
Sheridan Park Elementary
South Broward Family YMCA

Lauderdale Lakes:
Castle Hill Elementary
Lauderdale Lakes Middle School

Lauderhill:
Lauderhill Middle School
Lauderdale Paul Turner Elementary
Royal Palm Elementary

Miramar:
Annabel C. Perry Elementary
Calhoun Recreation Center
Whispering Pines School

Pembroke Park:
Lake Forest Elementary

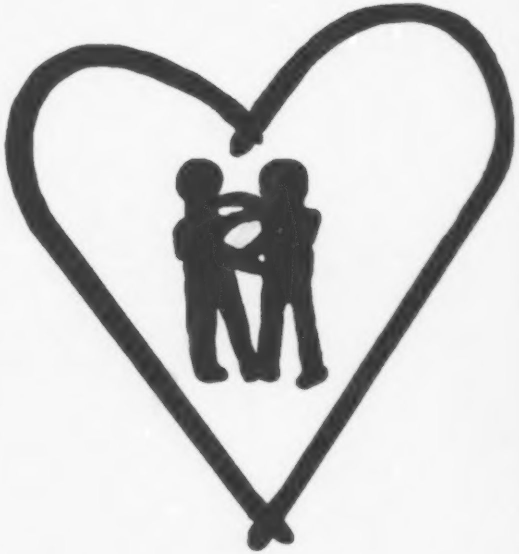
Plantation:
Mirror Lake Elementary
Plantation Elementary

Pompano Beach:
Bright Horizons
Charles Drew Elementary
Charles Drew Family Resource Center
Sanders Park Elementary

Sunrise:
Nob Hill Elementary

Weston:
Country Isles Elementary

BROWArD COUNTY INcLUSioN CHiLD CARE PrOjECT



www.ymcabroward.org

What doEs InclUsion MeAn?

An inclusive child care program has the same characteristics as any other child care program. In an inclusive program, children with and without disabilities participate in the same routines and activities. With the passage of the Americans with Disabilities Act (ADA) in 1990, child care providers, regardless of size, are obligated to integrate children with disabilities as long as the child's needs can be reasonably accommodated.

What is the ADA?

The Americans with Disabilities Act is a Civil Rights Law that prohibits discrimination against individuals with disabilities. The law states that businesses and municipalities must not deprive individuals, on the basis of a disability, of employment opportunities or access to services, programs or activities. It is the goal of the ADA to reasonably accommodate individuals with disabilities in order to integrate them into programs, based on individual needs.

What is the BroWard CounTy InclusioN ChiLd Care ProjEct?

Our Philosophy: It is our belief that all children have the same needs; to love and to be loved, to learn, to share, to grow. Children with disabilities are entitled to experience life as fully as their non-disabled peers.

Our Purpose: Our purpose is to provide support to school age providers in order to increase the availability of child care and recreation programs for children with disabilities.

Our Program: We strive to operate high quality child care programs for working families in accordance with all licensing rules and regulations and recommended national standards in school age child care. We believe that child care should provide opportunities and experiences that stimulate a child's physical, intellectual, emotional and social development. All programs are designed to meet the developmental needs of each age group and, most importantly, the individual needs of each child. We operate on a low staff to child ratio. Families with low incomes, in accordance with the provider's scholarship scale, may qualify for a reduced rate.

Our Staff: All staff demonstrate and teach the character development values of caring, honesty, respect and responsibility. Inclusion Project Staff have training and experience in working with children with disabilities. In addition, staff recognize that all children are distinct individuals with special strengths and needs.

Our Children: We provide child care for children with and without disabilities. Children in our inclusion programs become aware of differences and similarities between themselves and their peers. It is evident that children in inclusion programs benefit from an environment where emphasis is placed in being responsive to individual strengths and needs.

Who Can be A ProviDEr?

The YMCA will provide technical support, training, or direct services in cooperation with program providers upon request. Funding is available on a limited basis, to providers needing financial support to serve children with disabilities. Those providers desiring to operate their own inclusion program can apply to receive reimbursement through the Broward County Inclusion Child Care Project.* Interested providers are invited to contact the YMCA for an application or further information.

**based on availability of funding*

For MorE InfoRmaTion, Contact:

Cobi Dunn,
Association Inclusion Director

Mailing Address:
YMCA of Broward County
Association Office
5100 North Federal Highway
Suite 300-B
Fort Lauderdale, FL 33308

Phone:
954-489-2426 x229

Fax:
954-489-2428

E-mail:
cdunn@ymcabroward.org

Miami-Dade School Readiness Coalition

Inclusion Assistance Grant
September 18, 2002

The **Inclusion Assistance Grant** is a three-year project sponsored by the Florida Developmental Disabilities Council and is managed by the Miami-Dade School Readiness Coalition. An Advisory Committee representing community agencies and service providers provides input and guidance to the project. The primary outcome of this grant is to increase the number of early care and education programs providing quality services to children with disabilities and special needs.

First Year

Under the management of KIDCO, a total of $50,000 was offered as small grants to center-based and family child care homes interested in providing quality care to children with disabilities and special needs in a natural environment. Only those sites that were currently serving children with disabilities and special needs were contacted. Sixty-three early care and educations (42 center-based and 21 family child care home) requested funding monies. A total of $47,105 was awarded to 4 family child care homes ($3,789) and 9 center-based ($43,316). The unused balance was used to finance training for early care and education staff. At the end of the year the number of children with disabilities and special needs did not increase, however, the staff involved received the necessary training to optimally serve this population as well as the typical population.

Second Year

Under the management of the Miami-Dade School Readiness Coalition, two part-time Special Instruction Consultant (SIC) were hired to provide technical assistance and training to caregivers working with children with disabilities or special needs. The SIC began their assignment by providing services to the 63 early care and education programs who applied during the first year. During this year the number of early care and education programs interested on providing care for children with disabilities and special needs increased significantly to a 101. Also, the SIC discovered that parents needed support by providing resource and referral services. Toward the end of the year, SIC's from other agencies began coordinating services in order to use the available resources in a more productive manner.

Third Year

As a joint project between the Miami-Dade School Readiness Coalition and the Miami-Dade Regional Policy Council the **N.E.E.D.** (Natural Environment Educational Development) was proposed. This initiative will bring all the key players who serve children with disabilities and special needs from birth to school age, together in order to increase productivity and reduce duplication of services.

The proposal states that Miami-Dade County shall be divided into 5 clusters (regions), each to be served by one Special Instruction Consultant (SIC). The following are the proposed key players:

a) 5 SIC's will be provided,

- 2 part-time paid by the Inclusion Assistance Grant
- 1 part-time paid by the Coalition
- 1 full-time from Family Central (Central Agency)
- 1 full-time from Miami-Dade County- Child Development Services (Central Agency)

b) Service providers (speech and hearing, physical therapy, etc) will identify N.E.E.D programs at which they are already working and will serve as SIC's in those programs.

c) Central Agencies full-time SIC's will serve as service coordinators for children who are referred within their own areas 50% of their time and as SIC's providing services 50% of their time.

d) FDLRS Screening Outreach Specialist will serve non-N.E.E.D. centers requiring Level Two screening by talking to program staff, doing developmental screening with the child, if necessary, and determining what referral to make.

e) FDRLS Screening Specialist will continue to perform preschool screening for centers that do not serve subsidized children.

Approximately 1,500 surveys were mailed to all licensed facilities, inquiring if they were serving or would like to serve children with disabilities and special needs. Around a 100 responses were received from center-based and family child care homes. These early care and educations programs will be participating of the N.E.E.D. initiative.

Ivette Aponte-Torres, Program Director
305-646-7242, itorres@childreadiness.org

FLORIDA DEVELOPMENTAL DISABILITIES COUNCIL

Inclusion Assistance Grant

Miami-Dade County School Readiness Coalition
3250 SW Third Ave/Fifth Floor
Miami, Fl 33129   305-646-7220

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FLORIDA DEVELOPMENTAL DISABILITIES COUNCIL

Inclusion Assistance Grant

Miami-Dade County School Readiness Coalition

Special Instruction Consultant Participation Agreement

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9. Implement an individual special instruction plan that is consistent with the Family Support Plan or Individual Education Plan. The initial plan is developed jointly by the early care and education teacher, the family, and others involved in the provision of services for the child (e.g., therapists). The plan addresses the needs of the child and the specific activities to address those needs which will be used during the child's participation in the child care program. Updates of the individual special instruction plan are developed with input from the individuals in the initial plan.
10. This agreement will be in effect from the date signed until terminated by the child care center or family child care home care provider or the Inclusion Assistance Grant Advisory Committee.

Child Care Center / Family Child Care Home ______________________________

Owner / Operator / Director ______________________________

Signature ______________________________ Date ____________

FLORIDA DEVELOPMENTAL DISABILITIES COUNCIL
Inclusion Assistance Grant
Miami-Dade County School Readiness Coalition

3250 SW Third Ave/Fifth Floor
Miami, Florida 33129

Special Instruction Consultant Services

The Special Instruction Consultant Service is a program that assists childcare providers by observing and offering support and new ideas for the early care and education center or family child care home through a grant from the Florida Developmental Disabilities Council. We would like your permission for a Special Instruction Consultant to observe your child and help us adapt and modify our environment to meet the individual needs of your child. Theses services are offered at NO charge. Thank you for allowing us to better care for your child.

Please check one:

_____ **I do** give permission for my child to be observed by the Special Instruction Consultant to assist with meeting this/her needs.

_____ **I do not** give permission for my child to be observed by the Special Instruction Consultant to assist with meeting his/her needs.

Child's Name ____ DOB ____ Parent/Guardian Signature ____ Date ____

Child Care Center ____ Address ____

Child Care Center Professional ____ Title ____ Telephone/fax ____

For further information or to speak with a Special Instruction Consultant call:

Bethany Sands
305-646-7221
or
Carola Matera
305-646-7224

NOTICE OF PARENT'S RIGHTS AND DUE PROCESS
NOTIFICACION DE LOS DERECHOS DE LOS PADRES Y DEL PROCESO LEGAL

Dear Parent:

Due process consists of all the procedures written into law to safeguard your rights and the rights of your children. An important provision of the due process procedure is your right to receive and provide notification, information and consent written in the language you understand best. Be sure to obtain and keep all pertinent notices, information and consents.

The following is a summary of the due process procedure:

- You have the right to a full evaluation of your child's individual educational needs, and to be notified of and participate in planning your child's assessment.
- Specialized testing and exchange of confidential information used in the assessment process may only take place if you give your consent.
- You have the right to see all relevant school records of your child, and to request the school to change any information you feel is incorrect or misleading.
- You have the right to be notified of, and participate in team meetings to develop an Individual Education program for your child.

If you disagree with any decisions made about your child you are urged to meet with the appropriate Head Start staff and Parent Policy council to resolve the differences. If you cannot come to a satisfactory decision as a result of this meeting, you may initiate the following due process procedure:

- You have the right to an impartial hearing to clarify disagreements concerning identification, assessment and/or placement decisions. You may file for this impartial hearing with the State Superintendent of Public Instruction.
- You may bring representatives to the hearing to help you advocate for your child.
- If a satisfactory decision cannot be reached at the fair hearing, you may initiate a civil legal action.

Estimado Sr./Sra.:

El proceso legal consiste de todos los procedimientos escritos en la ley para salvaguardar sus derechos y los derechos de sus hijos. Una provisión muy importante del proceso legal es el procedimiento que especifica su derecho a recibir y de ser provisto de notificaciones, información y permisos por escrito en el idioma que Usted entienda mejor. Asegúrese de obtener y guardar todas las notificaciones, información y permisos que incumban a su hijo/a.

Lo siguiente es un resumen de los procedimientos en el proceso legal:

- *Usted tiene el derecho a una evaluación completa de las necesidades educacionales individualizadas de su hijo/a, de ser notifcado y participar en la planificación de dicha evaluación de su hijo/a.*
- *Se requiere su permiso por escrito para todos los exámenes especializados, así como para poder intercambiar información considerada confidencial, que vaya a ser usada en el proceso de la evaluación de su hijo/a.*
- *Usted tiene el derecho de revisar todos los reportes escolares concernientes a su hijo/a, y el derecho a pedir que la escuela cambie aquella información que Usted crea que es incorrecta o inexacta.*
- *Usted tiene el derecho a ser notificado de antemano y a participar en las reuniones del equipo para desarrollar el Programa Educacional Individualizado (IEP) de su hijo/a.*

Si Usted no está de acuerdo con cualquier decisión que sea hecha sobre su hijo/a se le urge que se reuna con el personal apropiado de Head Start y la Junta de Poliza Familiar para solucionar ese desacuerdo. Si no puede llegar a una decisión satisfactoria como resultado de esa reunión Usted puede iniciar los siguientes procedimientos del proceso legal:

- *Usted tiene el derecho a una audiencia imparcial para clarificar el desacuerdo concerniente a la identificación, la evaluación y/o la decisión de donde colocan a su hijo/a. Usted puede pedir esta audiencia imparcial con el Superintendente Estatal de Instrucción Pública.*
- *Usted puede traer representantes a esta audiencia para ayudarlo en la abogacía de su hijo/a.*
- *Si no se puede llegar a una decisión satisfactoria en la audiencia, usted puede comenzar acción legal en la corte civil.*

Map to Inclusive Child Care

A FEDERAL INITIATIVE TO PROMOTE INCLUSIVE CHILD CARE

A contract was awarded by the Child Care Bureau, Administration for Children and Families, Administration on Children, Youth and Families, U.S. Department of Health and Human Services to the University of Connecticut Health Center. The project offers an opportunity to ensure that children with disabilities, from birth through 12, have access to child care alongside their typically developing peers. Fueling the project is the premise that efforts to support child care providers in accommodating the individual needs of youngsters with disabilities can go hand-in-hand with improvements in the quality of care for all children.

The Map to Inclusive Child Care staff assists teams from each of the selected states to conduct a strategic planning process through which priorities and work plans are developed to address the needs of each state. The project staff supports each state team to meet their strategic planning objectives over the course of a year. The following states are participating in the Map to Inclusive Child Care Project: Alaska, Arizona, California, Colorado, Connecticut, Florida, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, Ohio, Oregon, Puerto Rico, Tennessee, Utah, Vermont, Virgin Islands, Washington DC, Washington, West Virginia and Wisconsin.

The Map to Inclusive Child Care Project provides technical assistance to selected states to design, implement and evaluate child care services to successfully include children with disabilities (ages birth to twelve). The technical assistance is conceptualized around a model of state-specific strategic planning in order to improve child care options and opportunities for children with disabilities and their families. In order to accomplish this effectively, the chosen states convene a state work team to devise a state work plan during a two–day planning retreat. Each state work team includes key stakeholders with knowledge, power, and resources related to state child care issues. Each state develops a plan based on the individualized needs of the state, creating a roadmap to high-quality, inclusive child care for children with disabilities.

Individuals interested in obtaining more information on the Map to Inclusive Child Care Project are encouraged to contact either Mary Beth Bruder, Ph.D., Project Director or Jennifer Joy, Project Coordinator at the Division of Child & Family Studies, University of Connecticut Health Center, The Exchange Building - MC6222, Farmington, Connecticut 06030-6222, Tel. (860) 679-1500; Fax (860) 679-1571.

Supported under Contract 105-97-1601 from the Child Care Bureau, Administration for Children and Families, Administration on Children, Youth and Families, U.S. Department of Health and Human Services to the University of Connecticut Health Center.

University of Connecticut Health Center
Division of Child and Family Studies
263 Farmington Avenue – MC 6222
Farmington, CT 06030

Telephone: (860) 679-1500
Fax: (860) 679-1571
email: Bruder@nso1.uchc.edu
email:Joy@nso1.uchc.edu

Year 1 States	Vision	Mission
Vermont	Every family in Vermont has the right to comprehensive, high quality child development services appropriate for their children. Every Vermont community shall nurture the healthy development of young children and strengthen families. To support communities, the State of Vermont will create a unified system for child development services which shares common standards for quality and respects the diversity and uniqueness of individuals and of programs.	To assure a statewide system that promotes and supports safe, accessible, quality child care for Vermont families
New Jersey	All children in New Jersey will have equal access to affordable, high quality, developmentally-appropriate, culturally competent child care.	All agencies/individuals who work with children will join together to ensure that: 1. All providers will be trained and well compensated to care for all children, including those with individualized special needs. 2. Government will offer incentives to providers to encourage them to become inclusive sites. 3. Families, providers and trainers will have access to affordable on-going training based on identified needs. Government and other public and private sources will help subsidize the training. 4. Technical consultation from therapists, educators, health providers, and other related services will be readily accessible across all settings in which children participate. 5. Staffing guidelines including ratios and qualifications, will be set to support the needs of all children in early care and educational (child care) settings. 6. Information on services and resources will be consolidated and disseminated to all who need it. 7. All programs will be family-centered with opportunities for family involvement in planning and implementation. 8. Families will have the opportunity to choose from a full spectrum of early care and educational (child care) options, including: non-traditional hours, a variety of settings and twelve month programs. 9. Cultural competence will be demonstrated in all aspects of early care and education.
Maryland	By the year 2003, quality child care choices will be equally available, affordable and accessible for all families in their communities.	Education, training and support will empower families and communities to create atmosphere of celebration and acceptance for children of all communities.
Tennessee	In the year 2003 all children and families in Tennessee will have access to quality affordable child care in their community.	To support and enhance child care services in Tennessee so that they can include children with disabilities.
Indiana	Indiana's Map to Inclusive Child Care initiative envisions a child care system where all Indiana families have access to quality child care.	Through data collection, analysis, and dissemination the Map initiative will enhance the capacity of Indiana's child care system to include children and youths with disabilities and special health care needs.
New Mexico	By the year 2003, all New Mexico children, youth, families and caregivers will have access to a comprehensive system of responsive quality care, education and family support that enhances growth and development.	To take collaborative action which will result in a comprehensive, affordable system of quality care for all children.
Iowa	Iowa has a quality, comprehensive affordable child care system easily accessible by families for **all** families.	To advocate, create, and support systematic change and enhancements in order to achieve and maintain comprehensive, quality, and affordable child care for **all** children.
Utah	By the year 2003 in Utah, all children regardless of disability will have access to and full participation in quality, affordable and flexible child care that supports and strengthens the development of individual children, their families and communities	The Utah Map Team will spearhead the formation of an inclusive child care system through public awareness, training and technical assistance, and collaboration with public and private agencies, community resources, families and legislators.
California	California's children with disabilities and other special needs have full access to quality inclusive child care that welcomes families and supports providers.	California's mission is to create a statewide system of support and resources that allow families and providers barrier free access to inclusive child care and youth services.
Oregon	The State of Oregon is committed to all children with disabilities and their families being able to choose appropriate quality care that is safe, community based, responsive to family needs and resources, affordable, accessible, and inclusive. The child care community will have access to the information, training, and resources necessary to ensure quality care. Policy makers and communities will be engaged in ongoing activities to support a comprehensive system of affordable care for children and youth with disabilities.	The mission of the Oregon Map team is to take lead to implement Oregon's strategic plan to access child care for children with special needs and their families.

Year 2 States	Vision	Mission
Massachusetts	The Massachusetts Map to Inclusive Child Care Team envisions supporting children with disabilities on the path to becoming participating, contributing adults in an equitable society by providing early care and education that: - Values all children - Responds to the unique needs of families - Enhances professionalism in the field - Creates comprehensive services through collaboration - Raises awareness and fosters positive attitudes towards child care - Is fully funded Thereby ensuring high quality care for all children.	The Massachusetts Map to Inclusive Child Care team is comprised of individuals who are committed to establishing a system for children and families of quality child care and education to ensure that all children , including those with disabilities, reach their maximum potential.
Puerto Rico	Inclusive communities in Puerto Rico, based on public policy that supports inclusion with collaborative agreements that foster quality, accessibility and availability of services centered in children, families and their communities.	To promote inclusion as an alternative of total quality services.
Washington DC	Final Vision to be completed August, 1999.	The DC Map to Inclusive Child Care Team is parents, child care providers, and agency representatives taking action to design and implement a supportive, comprehensive, culturally competent child care system, for all children, including those with special needs, and their families.
Florida	In the year 2004, all children and families will have access to all facets of the community. All communities will ensure the support, respect and resources necessary for all children to pursue their dreams and visions.	The expansion of quality, affordable, accessible child care services in community-based settings for a wide range of children with disabilities and special health care needs, and would include infants and toddlers, preschoolers and school-aged children. Community-based settings would include child care programs, after-school care programs and early childhood programs.
Illinois	All children in Illinois, including children with special needs, have access to high quality comprehensive and affordable child care.	To implement a system of inclusive, quality child care to insure access for children with special needs.
Louisiana	Families of children with special needs will have choice and access to quality, appropriate and affordable child care within their communities with a network of support.	To increase the number of qualified child care providers through the coordination and integration of efforts across care and support systems for all children in inclusive child care environments.
Missouri	All families can choose and receive child care that meet their needs and the needs of their child(ren).	The Special Needs Child Care Task Force will promote and enhance the development of programs and systems throughout the state which supports: - Providers in offering quality, inclusive early care and education for children with special needs - Parents in advocating for accessing quality care and education.
Colorado	We envision a society that recognizes and enhances the value and potential of each child and family.	To develop, disseminate, and promote the statewide adoption of a plan which addresses inclusive child care in Colorado by: - Finding out what exists, - Identifying resources, gaps and needs, - Getting feedback from stakeholders, - Making recommendations (a plan) that support implementation through collaboration.
Nevada	We envision that Nevada will support communities so that all families have access to quality child care options that accept and nurture the full participation of all children as individuals in collaborative programs where families are involved, satisfied, and content.	Our purpose is to provide leadership throughout the state on issues of inclusion in child care by working with existing initiatives (and creating new initiatives when appropriate) by: - Identifying resources - Policy development - Outreach to community leaders - Coordination of existing training and identifying gaps - Needs assessment - Increasing public awareness
Washington	We envision communities throughout the state where all children, youth and families are valued, and have access to quality inclusive child care offered by providers who are fully supported by coordinated resources from all sectors of society.	To increase access to quality inclusive child care and out-of-school care for children and youth throughout the state of Washington.

Inclusive Child Care Grant Awarded

Florida was one of ten states selected to participate in the Map to Inclusive ChildCare Project. A contract was awarded by the ChildCare Bureau, Administration on Children and Families, Department of Health and Human Services to Florida Department of Children and Families. The contract is for a twelve-month period being in April of 1999.

The contract offers an important opportunity to ensure that children with disabilities from birth through age 12 will have access to childcare alongside their more typically developing siblings and peers.

Florida's Department of Children and Families worked with representatives from many disciplines to identify ways to include all children with disabilities in traditional daycare and other childcare setting. The Florida Developmental Disabilities Council sponsored the workgroup whose efforts culminated with the production of its Five-Year Inclusive Child Care Strategic Plan. Florida officials believe that the new grant ward will greatly enhance the implementation of the State's Plan.

A state team for the Map to Inclusive ChildCare Project has been formed. A member of the Florida Developmental Disabilities Council, Susan Gold, Ed.D and staff, Beth Swisher are members of the team. They will be participating in strategic planning efforts and a two-day national institute on inclusive childcare in Washington, D.C. on August 12-13.

Please posted under coming events.

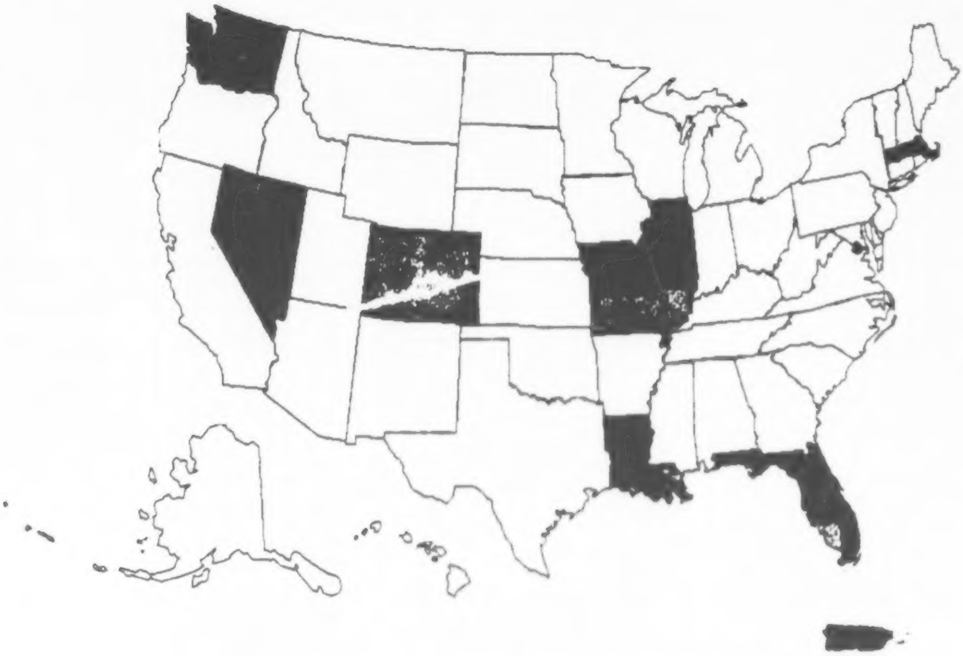
2nd Annual Career Day Job Fair for people with disabilities. Sponsored by the Florida Department of Labor and Employment Security's, Divisions of Vocational Rehabilitation and Blind Services.

The 2nd Annual Career Day will be held at:

Marks Street Senior Recreation Complex
99 East Mark Street
Orlando, Fl 32803

On: August 10, 1999 – 8:00 a.m. to 12:00 p.m.

Map to Inclusive Child Care National Institute



August 12-13, 1999

Washington, DC

Year 1 States	Vision	Mission
Vermont	Every family in Vermont has the right to comprehensive, high quality child development services appropriate for their children. Every Vermont community shall nurture the healthy development of young children and strengthen families. To support communities, the State of Vermont will create a unified system for child development services which shares common standards for quality and respects the diversity and uniqueness of individuals and of programs.	To assure a statewide system that promotes and supports safe, accessible, quality child care for Vermont families
New Jersey	All children in New Jersey will have equal access to affordable, high quality, developmentally-appropriate, culturally competent child care.	All agencies/individuals who work with children will join together to ensure that: 1. All providers will be trained and well compensated to care for all children, including those with individualized special needs. 2. Government will offer incentives to providers to encourage them to become inclusive sites. 3. Families, providers and trainers will have access to affordable on-going training based on identified needs. Government and other public and private sources will help subsidize the training. 4. Technical consultation from therapists educators, health providers, and other related services will be readily accessible across all settings in which children participate. 5. Staffing guidelines including, ratios and qualifications, will be set to support the needs of all children in early care and educational (child care) settings. 6. Information on services and resources will be consolidated and disseminated to all who need it. 7. All programs will be family-centered with opportunities for family involvement in planning and implementation. 8. Families will have the opportunity to choose from a full spectrum of early care and educational (child care) options, including: non-traditional hours, a variety of settings, and twelve month programs. 9. Cultural competence will be demonstrated in all aspects of early care and education.
Maryland	By the year 2003. Quality child care choices will be equally available, affordable and accessible for all families in their communities.	Education, training and support will empower families and communities to create atmosphere of celebration and acceptance for children of all communities.
Tennessee	In the year 2003 all children and families in Tennessee will have access to quality affordable child care in their community.	To support and enhance child care services in Tennessee so that they can include children with disabilities.
Indiana	Indiana's Map to Inclusive Child Care initiative envisions a child care system where all Indiana families have access to quality child care.	Through data collection, analysis, and dissemination, the Map initiative will enhance the capacity of Indian's child care system to include children and youths with disabilities and special health care needs.
New Mexico	By the year 2003, all New Mexico children, youth, families and caregivers will have access to a comprehensive system of responsive quality care, education and family support that enhances growth and development.	To take collaborative action which will result in a comprehensive, affordable system of quality care for all children.
Iowa	Iowa has a quality, comprehensive affordable child care system easily accesses by families for **all** families.	To advocate, create, and support systematic change and enhancements in order to achieve and maintain comprehensive, quality, and affordable child care for **all** children.
Utah	By the year 2003 in Utah, all children regardless of disability will have access to and full participation in quality, affordable and flexible child care that supports and strengthens the development of individual children, their families and communities.	The Utah Map Team will spearhead the formation of an inclusive child care system through public awareness, training and technical assistance, and collaboration with public and private agencies, community resources, families and legislators.
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Oregon	The State of Oregon is committed to all children with disabilities and their families being able to choose appropriate quality care that is safe, community based, responsive to family needs and resources, affordable, accessible, and inclusive. The child care community will have access to the information, training, and resources necessary to ensure quality care. Policy makers and communities will be engaged in ongoing activities to support a comprehensive system of affordable care for children and youth with disabilities.	The mission of the Oregon Map team is to take lead to implement Oregon's strategic plan to access to child care for children with special needs and their children.

Year 2 States	Vision	Mission
Massachusetts	The Massachusetts Map to Inclusive Child Care Team envisions supporting children with disabilities on the path to becoming participating, contributing adults in an equitable society by providing early care and education that: ▪ Values all children ▪ Responds to the unique needs of families ▪ Enhances professionalism in the field ▪ Creates comprehensive services through collaboration ▪ Raises awareness and fosters positive attitudes towards child care ▪ Is fully funded Thereby ensuring high quality care for all children.	The Massachusetts Map to Inclusive Child Care team is comprised of individuals who are committed to establishing a system for children and families of quality child care and education to ensure that all children , including those with disabilities, reach their maximum potential.
Puerto Rico	Final Vision to be completed August, 1999.	Final Mission to be completed August, 1999.
Washington DC	Final Vision to be completed August, 1999.	The DC Map to Inclusive Child Care Team is parents, child care providers, and agency representatives taking action to design and implement a supportive, comprehensive, culturally competent child care system, for all children, including those with special needs, and their families.
Florida	In the year 2004, all children and families will have access to all facets of the community. All communities will ensure the support, respect and resources necessary for all children to pursue their dreams and visions.	The expansion of quality, affordable, accessible child care services in community-based settings for a wide range children with disabilities and special health care needs, and would include infants and toddlers, preschoolers and school-aged children. Community based settings would include child care programs, and after-school care programs and early childhood programs.
Illinois	All children in Illinois, including children with special needs, have access to high quality comprehensive and affordable child care.	To implement a system of inclusive, quality child care to insure access for children with special needs.
Louisiana	Families of children with special needs will have choice and access to quality, appropriate and affordable child care within their communities with a network of support.	To increase the number of qualified child care providers through the coordination and integration of efforts across care and support systems for all children in inclusive child care environments.
Missouri	All families can choose and receive child care that meet their needs and the needs of their child(ren).	The Special Needs Child Care Task Force will promote and enhance the development of programs and systems throughout the state which support: ▪ Providers in offering quality, inclusive early care and education for children with special needs ▪ Parents in advocating for accessing quality care and education.
Colorado	We envision a society that recognizes and enhances the value and potential of each child and family.	To develop, disseminate, and promote the statewide adoption of a plan which addresses inclusive child care in Colorado by: ▪ Finding out what exists, ▪ Identifying resources, gaps and needs, ▪ Getting feedback from stakeholders, ▪ Making recommendations (a plan) that support implementation through collaboration.
Nevada	We envision that Nevada will support communities so that all families have access to quality child care options that accept and nurture the full participation of all children as individuals in collaborative programs where families are involved, satisfied, and content.	Our purpose is to provide leadership throughout the state on issues of inclusion in child care by working with existing initiatives (and creating new initiatives when appropriate) by: ▪ Identifying resources ▪ Policy development ▪ Outreach to community leaders ▪ Coordination of existing training and identifying gaps ▪ Needs assessment ▪ Increasing public awareness
Washington	We envision communities throughout the state where all children, youth and families are valued, and access to quality inclusive child care offered by providers who are fully supported by coordinated resources from all sectors of society.	To increase access to quality inclusive child care and out-of-school care for children and youth throughout the state of Washington.

Clay County Inclusive Childcare Project

Dear Disability Council Members:

In 1998 Lighthouse became involved with the Florida Inclusive Child Care work group.

The work group put into place a strategic plan. The plan put into place initiatives that would design improvement, accessibility, availability and affordable quality child care for Special Needs children through our State of Florida.

Developmental Disabilities Council along with Children and Families provided funding for two pilot programs. One program was to be urban and the other was to be rural. The two projects chosen were the Miami Mailman Center and the Clay County Inclusive Child Care Project. Since that time, other projects have been underway.

We continue to provide the services, training and support for preschools to work with children with disabilities.

Advisory Board

Cathy Grant	Educator
Dr. Dwight Bayley	Doctor of Ministry
Kim Clayton	Parent
Mark Ahsley	Parent
Kathy Schevrman	Business Owner
Whitney Milso	Disability Coordinator
Paige Degryse	Director of Lighthouse
Theresa Woodward	First Coast Technical Center

Overview of the Clay County Inclusive Childcare Project
1999-2001

This pilot project was designed to initiate the acceptance of inclusion in a rural community in Northeast Florida. Its mission was two-fold: 1) bring about an acceptance on the part of child care directors and workers to including Special Needs children in their programs, and 2) training childcare workers to improve the level of care for Special Needs children in the county.

Awareness of inclusive childcare was virtually nonexistent at the beginning of this project. Special Needs children were being served by local centers, however the level of care was totally unacceptable. Children were spending the day in high chairs and/or restricted to certain areas of the center, and none were interacting with their age group peers. Children were placed in rooms based on their level of functioning, not their chronological age.

The initial phase of the project was devoted to identifying both commercial centers and home-based caregivers. After the centers and homes were identified, the Community Coordinator visited each center. An overview of the project and its mission was explained to directors, and they were invited to participate in the trainings.

The level of resistance was surprising. Many centers felt the care given to Special Needs children was adequate, and that they and their staff did not need additional training. Few expressed interest in participating in the trainings.

Due to the level of resistance, the decision was made to proceed slowly and establish better working relationships with the centers. After this rapport had been established, we once again encouraged dialogue about inclusion and participation in the trainings.

As the project's initial phase nears completion, progress is slow. Participation in the trainings is not to the desired level. The biggest obstacles to realizing full inclusive childcare in the county are financial constraints on the part of the centers. Adding to this is the extremely high turnover rate and quality of workers in the centers. However, it is felt a great deal of progress has been made in the areas of identification of Special Needs children, acceptance of the need for inclusion, and the level of cooperation among centers in Clay County. The focus of the project's next phase will be to build on the relationships that have been formed over the past two years.

Overview of the Clay County Inclusive Childcare Project
2001-2002

In the last phase of the project was to continue to maintain strong relationships with the Preschool Programs.

We continue to offer Mitch training. The trainings were even done at the Preschool's Centers if requested.

During the Mitch training, there were many concerns and questions. Our agency then decided to increase our scope of in-service trainings. Hopefully, these would help providers become more open about taking Special Needs children.

We also began seeing children in daycare for Physical Therapy, Occupational Therapy, and Speech Therapy, individual education sessions. This was due to the growing "natural environment" movement for birth to three children. This in itself helped with awareness of children. Some centers weren't even aware that the child had delays.

Lighthouse partnered with First Coast Technical Institute who are the childcare training facility. When the Special Needs module was being taught, they were done at Lighthouse with the assistance of the staff.

The Lighthouse program began to feel a greater need for inclusion at our school. We opened two more classes of inclusion.

Our next obstacle was the cost and availability of toys and equipment for the enter that had Special Needs children. We loaned our equipment and toys but began to realize this could become a problem.

We researched equipment and toys and found the National Lekotek Center in Illinois. We contacted the center and within four months, five staff from Lighthouse were going through National Lekotek training. We are the only National Lekotek trained center in Florida. Our area covers all of Northeast Florida. One of our advisory council members gave us information about a grant. We proceeded with writing four grants. Lighthouse received three of those grants for a total of $44,000. Our parent company, CCAR Services, Inc., gave up space in a mall and we began ordering equipment and toys. Centers now had a place to come and gather toys and equipment they needed for their children. The therapists also assist with equipment needs.

There are still obstacles that will be of ongoing concern though I believe we have made some great smaller steps.

Our center still continues to work with centers on inclusion through education, workshops, and visits to the centers.

PROVIDER CHILD CARE SURVEY

THANKS for taking a few moments to complete this survey. You may indicate your name and the name of your center if you desire, otherwise all responses will be anonymous. If you have additional comments, please write them at the end of this survey. Either check, circle your answer or fill in the blank. If you have any questions about this survey, please call 264-7392and ask fur Robin St. Peter. Thanks!!

1. My facility is: (check all that apply)

______Licensed Child Care Facility
______Licensed Family Day Care Home
______Not-for-Profit Facility
______Early Intervention Program
______Nursery/Preschool Program
______Local Business providing child care
______Community Recreation Program
______Church or Synagogue Child Care
______Other Child Care Provider
______Rehabilitation Facility
______Other: ______________________________

______Registered Child Care Facility
______For-Profit Facility
______Head Start Center
______Public School
______Medical Facility
______State funded Pre-K program
______Volunteer Organization
______Exempt Child Care Provider
______Before/After School Program.
______Religious School

BEST COPY AVAILABLE

2. I and/or my staff have had training in the past 12 months that focused on providing child care to children with disabilities or special health care needs. ____No ____ Yes: Where and what type? ______________________________

2. Number of employees at my facility:______

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3. Please indicate the number of employees who have completed: ____ 6th grade ____ 8th grade ____ 10th grade

____ HS Diploma ____ CDA ____2-yr Associate ____ 4-yr Bachelor ____ Masters Degree ____ Other

4. My program serves children with disabilities/special health care needs ____ No (go to question #6)
____ Yes (go to question #5)

5. Below are various descriptors. Please check all that apply to your program as it relates to serving children with disabilities/special health care needs. Make notes if the categories don't fit your needs.

a. Types of disabilities/special health care needs:
____ Developmental Delays
____ Speech/Language or communication delays
____ Mental retardation
____ Medical Diagnosis needing specialized care (e.g., seizures, cerebral palsy)
____ Vision Impairment
____ Hearing Impairment
____ Drug/Substance Exposed
____ Attention Deficit Disorder/Hyperactivity
____ Autism
____ Behavior Disorders
____ Other: ________________________________

b. Child Care is ____ Inclusive with age peers ____ Self-contained ____ Mixed settings

c. Our facility is handicapped accessible/ADA compliant ____ Yes ____ No

d. Do any of the children in your program have a 1:1 aide with them? ____ No ____ Yes How many?______

BEST COPY AVAILABLE

e. How were these children referred to your program?

____ Were already participating before disability was identified
____ Parent Referral
____ Public School Referral
____ Early Intervention System Referral
____ Social Service Agency Referral
____ Sibling attending program
____ Other: ____________________

f. What do YOU do when you suspect a child has a developmental problem or disability?

____ Refer to local Early Intervention System
____ Refer to local Public School
____ Tell the parents of my concerns
____ Nothing
____ Ask the family to find other child care
____ Refer to in-house resources
____ This has never happened
____ Other: ____________________

6. What supports or services would help you to provide child care for more children with disabilities or to improve the services that you currently provide? CHECK UP TO FIVE AND THEN CIRCLE THE ONE THAT WOULD BE MOST IMPORTANT TO YOU.

____ Workshops and Conference Training Opportunities
____ Distance Learning Opportunities
____ On-Site Training/Technical Assistance - General
____ On-Site Training/Technical Assistance - child specific

____ Written materials
____ Audio Materials
____ Materials for classroom use
____ Videos
____ Visits to Inclusive Programs
____ Equipment for classroom, playground use

BEST COPY AVAILABLE

LIST CONTINUED NEXT PAGE

____ Additional staff - part time
____ Volunteers
____ Additional funding to support current staff
____ Additional funding for additional staff
____ Other ____
____ Additional staff - full time
____ Specialized staff (therapists) on-site
____ Funds to support facilities modifications (ADA)
____ Information about specific disabilities

7. Is liability insurance a problem for you related to serving children with disabilities/special health care needs?
____ No ____ Yes (In what way?) ____

8. The following questions relate to your participation in multi disciplinary teams who develop Individualized Family Service/Support Plans (IFPSPs) for children Birth-2, or Individualized Education Plans (IEPs) for children 3-21 with disabilities, developmental delays and/or special health care needs. Simply CHECK if the statement is true for you; leave blank otherwise.

____ I or someone from our program staff have participated in an IFSP meeting for a child enrolled in our program.
____ I or someone from our program staff have participated in an IEP meeting for a child enrolled in our program.
____ I or someone from our program staff have a copy of the child's IFSP or IEP.
____ There are goals/objectives in the IFSP or IEP that I or someone from our program staff carries out while the child is with us.
____ I don't know anything about IFSPs.
____ I don't know anything about IEPs.

CONTINUED ON NEXT PAGE

____ Staff from the local Early Intervention Program come to our program and provide services to children while they are with us.

____ Staff from the local Public School come to our program and provide services to children while they are with us.

____ We commonly receive referrals from the local Early Intervention Program to serve children with disabilities/ special health care needs.

____ We commonly receive referrals from the local Public School to serve children with disabilities/special health care needs.

____ Other: ____________________

9. Do you need information about (check all that apply):

____ Individuals with Disabilities Education Act (IDEA)
____ Child care licensing and/or registration requirements
____ Florida Children's Forum
____ Americans with Disabilities Act (ADA)
____ Florida's Central Directory of services for families and children with disabilities/special health care needs

____ Other: ____________________

10. Please share ideas, suggestions, innovative practices and collaborations that have worked for you: ____________________

11. If only ONE thing could be done in the next year to make it possible for you to serve children with disabilities/special health care needs, what would that ONE thing be?

12. General Comments

13. OPTIONAL

Your name:

Name and address of your facility:

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS SURVEY!!

Trainings:

Centers attended: 31
Home Daycares: 3

Trainings Offered:

Mitch

Sensory Play

Equipment -n- Toys

Seizures/Medications

Snoezelen

Working with Occupational, Physical and Speech Therapy

Siblings

Centers and home day cares were each visited for a total of 88 visits combined:

Comments are as follows:

1. Not enough staff to cover special needs students.
2. Would not take special needs children.
3. Their school is an academic preschool program and "we can't handle kids like that".
4. Might be willing to try.
5. Interested in participating.
6. Closed down in face.
7. Just a babysitter.
8. Polite but not enthusiastic.
9. Programs of their own.
10. Very receptive.
11. Open to ideas of inclusion.

RECORD OF CENTER VISIT

Name & Address of Center: ______________________ Date: ______________

____

____

Name of Owner/Director/Supervisor: ______________________

Type of Program: ______________________ No. of Children Enrolled: ______________

No. of Staff: _______ Any Special Training to Handle Special Needs Children? _____Y ___N

NAEYC Accredited? ____Y ____N Knowledge of Child Find/EIP? ____Y ____N

Ages of Children _________ Hours of Care ____________

Best Time for Training _____ Evenings _____ Saturdays

Children with Disabilities/Special Health Care Needs? _____ Types of Disabilities ___________

____

Handicap Accessibility: ______________________

Concerns: ______________________

____

____

____

Comments: ______________________

____

____

____

____

____

RECORD OF PROVIDER CONTACT

Center: ______________________________ Date: __________

Person(s) Contacted: ______________________________

Reason for Visit: ______________________________

Action: ______________________________

Outcome: ______________________________

Follow Up: ______________________________

LIGHTHOUSE LEARNING CENTER

EVALUATION OF PRESENTATION

Date: ____________________

Title of Presentation ____

Trainer/Speaker: ____

PLEASE CHECK ONE RATING PER ITEM

	EXCELLENT	VERY GOOD	GOOD	FAIR	POOR
Preparation & Organization					
Usefulness of content					
Audiovisual Aids					
Handouts					
Facilities					
Opportunity for participation					
Knowledge of presenter					
Applicable to local needs					
Atmosphere set by presenter					

Did this workshop meet, exceed, or fail to meet your expectations? ______________

If failed to meet, what improvements would you suggest? ______________

____

____

____

How will you be able to use the information you heard? ______________

____

____

____

____

____

A Commitment to Quality Care for all Clay County Children

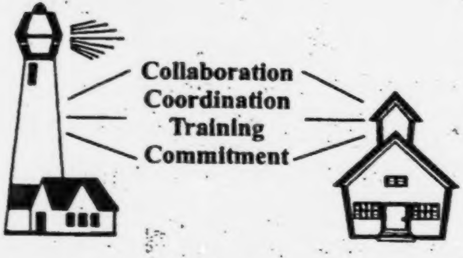
Collaboration
Coordination
Training
Commitment

Lighthouse Learning Center and Clay County Child Care Providers are Currently Involved in an Intensive Training Program to Ensure Quality Inclusive Care Throughout Clay County

For More Information Call
(904) 264-7392

Made Possible Through a Grant from the Florida Developmental Disabilities Council and the Florida Department of Children and Families.

Lighhthouse Learning Center and Clay County Child Care Providers are Offering a New Approach to Child Care...



Inclusion

What is Inclusion?

Inclusion is a unique approach to child care. Inclusive programs offer nondisabled and disabled children interacting in the same environment.

Where can I find Inclusive Programs?

Lighthouse Learning Center and Clay County Child Care Providers are currently involved in an intensive training program aimed at ensuring quality Inclusive care throughout Clay County.

How can I enroll my child in an Inclusive Program?

For more information call (904)264-7392.

LIGHTHOUSE LEARNING CENTER SERVICES

- Educational Classroom
- Parent Education, Support, and Counseling
- Family Case Management
- Home Visits - Duval County
- Individual Educational Sessions
- Special Needs Children
- Inclusion Class
- Snoezelen (Sensory) Room
- Nursing Services
- Extended Before and After School Program
- Early Intervention Clinics at Lighthouse
- Early Intervention Clinics with Gainesville Program
- Summer Recreational Program
- Physical Therapy
- Occupational Therapy
- Speech and language Therapy
- Applying Early Brain Development
- Florida Scholar Program
- Youth and Adult Volunteer Program
- Lekotek Library
- Sibshop
- Working with area high schools to give work experience to students with disabilities

A child's work: fostering
development through play.

Toy Library

548 Kingsley Ave – Orange Park, FL 32073
(904) 269-5515

Tuesday and Thursday - 9 a.m. to 3 p.m.
(other times available by appointment)

Come visit us and see our great selection of educational toys, games, puzzles and manipulatives that are available for checkout.

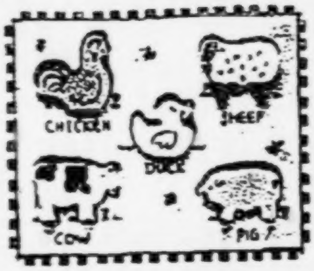
Membership is open to all - parents, grandparents and educators.

Our workroom includes an Ellison machine, laminator and a book binder.

Therapeutic Equipment

Parent Resources

For children ages 0 to 8 years old.



lekotek

Toy Library

@

Lighthouse Learning Center

A child's work: fostering development through play.

548 Kingsley Ave • Orange Park, FL 32073
(904) 269-5515

NEW FAMILY APPLICATION

Social Security Number ____________________ Date ____________________

Last Name ____________________ First Name ____________________

Street ____

City ____________________ State ____________ Zip ____________

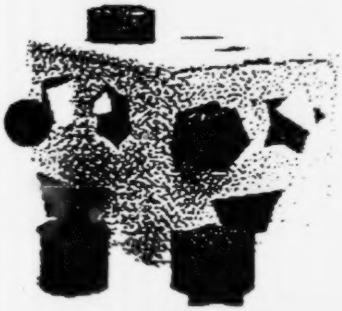
County ____________________ Home Phone Number ____________________

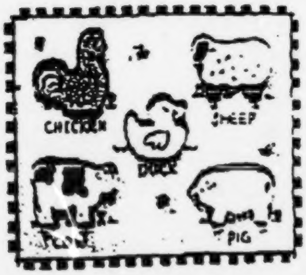
	Child's Last Name	First Name	Date of Birth
1.			
2.			
3.			
4.			
5.			

Does your child have any special needs? ____

____

Email Address ____________________





lekotek
Toy Library

548 Kingsley Ave • Orange Park, FL 32073
(904) 269-5515

A child's work: fostering development through play.

Check-out Form

Name ______________________ Date ______________

Patron ID # ________________ Date items are due ______________

Item Bar code number

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

I understand that I am to report any damage or lost pieces when I return the items I have checked out. I agree to take care of the items, and I will replace or pay the replacement cost of any items damaged, destroyed, or lost due to my negligence. I understand that The Toy Library is not responsible for accidents or injury that may occur while items are in my possession. If I cannot return the item by the due date, I will call the library. I understand that adult supervision is necessary when children are using the items.

____
Signature Date

HEY KIDS!

(oh, and parents, too!)

Do you have a brother or sister with special developmental needs?

Do you like...

[illegible]

Crazy games?

Yummy food?

Meeting other cool kids?

If you said "YES!" to these questions, we want you to join us at

Sibshops

They are lively events led by energetic adults where you can meet other kids who have siblings with special developmental needs, play games, eat, and share some of your experiences about being a sibling of a kid with special needs.

Sibshops are held one Saturday a month
from 10:00 a.m. - 2:00 p.m.
at Lighthouse Learning Center in Orange Park.

For more information about Sibshops and registration, please contact Lighthouse Learning Center at #264-7392.

Continuing Concerns

- continue to find some lack of interest in having Special Needs children
- centers understanding disabilities
- center staff turnover is high
- equipment and toys for centers to use
- ongoing workshop and training
- public awareness and support

NOTES

Map to Inclusive Child Care

A FEDERAL INITIATIVE TO PROMOTE INCLUSIVE CHILD CARE

A contract was awarded by the Child Care Bureau, Administration for Children and Families, Administration on Children, Youth and Families, U.S. Department of Health and Human Services to the University of Connecticut Health Center. The project offers an opportunity to ensure that children with disabilities, from birth through 12, have access to child care alongside their typically developing peers. Fueling the project is the premise that efforts to support child care providers in accommodating the individual needs of youngsters with disabilities can go hand-in-hand with improvements in the quality of care for all children.

The Map to Inclusive Child Care staff assists teams from each of the selected states to conduct a strategic planning process through which priorities and work plans are developed to address the needs of each state. The project staff supports each state team to meet their strategic planning objectives over the course of a year. The following states are participating in the Map to Inclusive Child Care Project: Alaska, Arizona, California, Colorado, Connecticut, Florida, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, Ohio, Oregon, Puerto Rico, Tennessee, Utah, Vermont, Virgin Islands, Washington DC, Washington, West Virginia and Wisconsin.

The Map to Inclusive Child Care Project provides technical assistance to selected states to design, implement and evaluate child care services to successfully include children with disabilities (ages birth to twelve). The technical assistance is conceptualized around a model of state-specific strategic planning in order to improve child care options and opportunities for children with disabilities and their families. In order to accomplish this effectively, the chosen states convene a state work team to devise a state work plan during a two–day planning retreat. Each state work team includes key stakeholders with knowledge, power, and resources related to state child care issues. Each state develops a plan based on the individualized needs of the state, creating a roadmap to high-quality, inclusive child care for children with disabilities.

Individuals interested in obtaining more information on the Map to Inclusive Child Care Project are encouraged to contact either Mary Beth Bruder, Ph.D., Project Director or Jennifer Joy, Project Coordinator at the Division of Child & Family Studies, University of Connecticut Health Center, The Exchange Building - MC6222, Farmington, Connecticut 06030-6222, Tel. (860) 679-1500; Fax (860) 679-1571.

Supported under Contract 105-97-1601 from the Child Care Bureau, Administration for Children and Families, Administration on Children, Youth and Families, U.S. Department of Health and Human Services to the University of Connecticut Health Center.

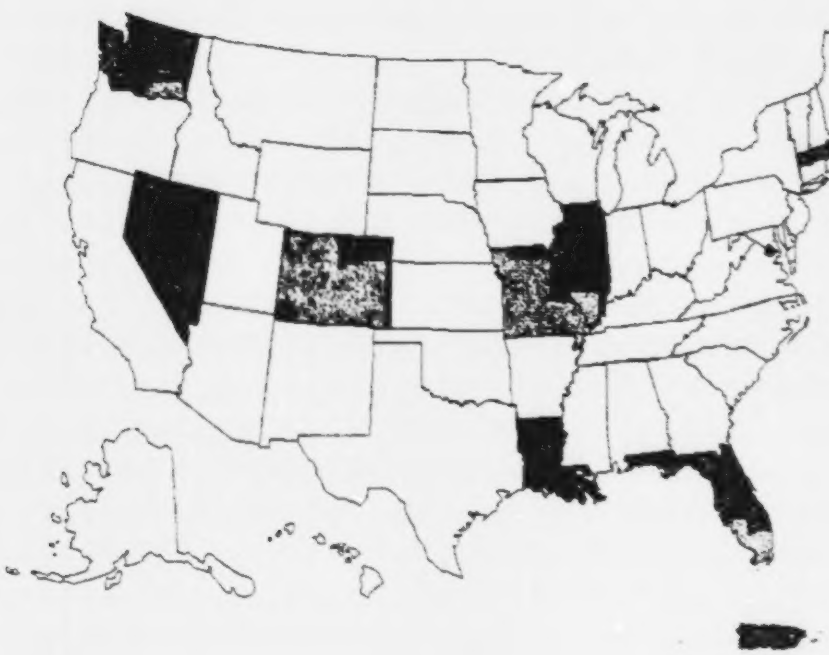
University of Connecticut Health Center
Division of Child and Family Studies
263 Farmington Avenue – MC 6222
Farmington, CT 06030

Telephone: (860) 679-1500
Fax: (860) 679-1571
email: Bruder@nso1.uchc.edu
email:Joy@nso1.uchc.edu

Year 1 States	Vision	Mission
Vermont	Every family in Vermont has the right to comprehensive, high quality child development services appropriate for their children. Every Vermont community shall nurture the healthy development of young children and strengthen families. To support communities, the State of Vermont will create a unified system for child development services which shares common standards for quality and respects the diversity and uniqueness of individuals and of programs.	To assure a statewide system that promotes and supports safe, accessible, quality child care for Vermont families
New Jersey	All children in New Jersey will have equal access to affordable, high quality, developmentally-appropriate, culturally competent child care.	All agencies/individuals who work with children will join together to ensure that: 1. All providers will be trained and well compensated to care for all children, including those with individualized special needs. 2. Government will offer incentives to providers to encourage them to become inclusive sites. 3. Families, providers and trainers will have access to affordable on-going training based on identified needs. Government and other public and private sources will help subsidize the training. 4. Technical consultation from therapists, educators, health providers, and other related services will be readily accessible across all settings in which children participate. 5. Staffing guidelines including ratios and qualifications, will be set to support the needs of all children in early care and educational (child care) settings. 6. Information on services and resources will be consolidated and disseminated to all who need it. 7. All programs will be family-centered with opportunities for family involvement in planning and implementation. 8. Families will have the opportunity to choose from a full spectrum of early care and educational (child care) options, including: non-traditional hours, a variety of settings and twelve month programs. 9. Cultural competence will be demonstrated in all aspects of early care and education.
Maryland	By the year 2003, quality child care choices will be equally available, affordable and accessible for all families in their communities.	Education, training and support will empower families and communities to create atmosphere of celebration and acceptance for children of all communities.
Tennessee	In the year 2003 all children and families in Tennessee will have access to quality affordable child care in their community.	To support and enhance child care services in Tennessee so that they can include children with disabilities.
Indiana	Indiana's Map to Inclusive Child Care initiative envisions a child care system where all Indiana families have access to quality child care.	Through data collection, analysis, and dissemination the Map initiative will enhance the capacity of Indiana's child care system to include children and youths with disabilities and special health care needs.
New Mexico	By the year 2003, all New Mexico children, youth, families and caregivers will have access to a comprehensive system of responsive quality care, education and family support that enhances growth and development.	To take collaborative action which will result in a comprehensive, affordable system of quality care for all children.
Iowa	Iowa has a quality, comprehensive affordable child care system easily accessible by families for **all** families.	To advocate, create, and support systematic change and enhancements in order to achieve and maintain comprehensive, quality, and affordable child care for **all** children.
Utah	By the year 2003 in Utah, all children regardless of disability will have access to and full participation in quality, affordable and flexible child care that supports and strengthens the development of individual children, their families and communities.	The Utah Map Team will spearhead the formation of an inclusive child care system through public awareness, training and technical assistance, and collaboration with public and private agencies, community resources, families and legislators.
California	California's children with disabilities and other special needs have full access to quality inclusive child care that welcomes families and supports providers.	California's mission is to create a statewide system of support and resources that allow families and providers barrier free access to inclusive child care and youth services.
Oregon	The State of Oregon is committed to all children with disabilities and their families being able to choose appropriate quality care that is safe, community based, responsive to family needs and resources, affordable, accessible, and inclusive. The child care community will have access to the information, training, and resources necessary to ensure quality care. Policy makers and communities will be engaged in ongoing activities to support a comprehensive system of affordable care for children and youth with disabilities.	The mission of the Oregon Map team is to take lead to implement Oregon's strategic plan to access child care for children with special needs and their families.

Year 2 States	Vision	Mission
Massachusetts	The Massachusetts Map to Inclusive Child Care Team envisions supporting children with disabilities on the path to becoming participating contributing adults in an equitable society by providing early care and education that: • Values all children • Responds to the unique needs of families • Enhances professionalism in the field • Creates comprehensive services through collaboration • Raises awareness and fosters positive attitudes towards child care • Is fully funded Thereby ensuring high quality care for all children.	The Massachusetts Map to Inclusive Child Care team is comprised of individuals who are committed to establishing a system for children and families of quality child care and education to ensure that all children , including those with disabilities, reach their maximum potential.
Puerto Rico	Inclusive communities in Puerto Rico, based on public policy that supports inclusion with collaborative agreements that foster quality, accessibility and availability of services centered in children, families and their communities.	To promote inclusion as an alternative of total quality services.
Washington DC	Final Vision to be completed August, 1999.	The DC Map to Inclusive Child Care Team is parents, child care providers, and agency representatives taking action to design and implement a supportive, comprehensive, culturally competent child care system, for all children, including those with special needs, and their families.
Florida	In the year 2004, all children and families will have access to all facets of the community. All communities will ensure the support, respect and resources necessary for all children to pursue their dreams and visions.	The expansion of quality, affordable, accessible child care services in community-based settings for a wide range of children with disabilities and special health care needs, and would include infants and toddlers, preschoolers and school-aged children. Community-based settings would include child care programs, after-school care programs and early childhood programs.
Illinois	All children in Illinois, including children with special needs, have access to high quality comprehensive and affordable child care.	To implement a system of inclusive, quality child care to insure access for children with special needs.
Louisiana	Families of children with special needs will have choice and access to quality, appropriate and affordable child care within their communities with a network of support.	To increase the number of qualified child care providers through the coordination and integration of efforts across care and support systems for all children in inclusive child care environments.
Missouri	All families can choose and receive child care that meet their needs and the needs of their child(ren).	The Special Needs Child Care Task Force will promote and enhance the development of programs and systems throughout the state which supports: • Providers in offering quality, inclusive early care and education for children with special needs • Parents in advocating for accessing quality care and education.
Colorado	We envision a society that recognizes and enhances the value and potential of each child and family.	To develop, disseminate, and promote the statewide adoption of a plan which addresses inclusive child care in Colorado by: • Finding out what exists, • Identifying resources, gaps and needs, • Getting feedback from stakeholders, • Making recommendations (a plan) that support implementation through collaboration.
Nevada	We envision that Nevada will support communities so that all families have access to quality child care options that accept and nurture the full participation of all children as individuals in collaborative programs where families are involved, satisfied, and content.	Our purpose is to provide leadership throughout the state on issues of inclusion in child care by working with existing initiatives (and creating new initiatives when appropriate) by: • Identifying resources • Policy development • Outreach to community leaders • Coordination of existing training and identifying gaps • Needs assessment • Increasing public awareness
Washington	We envision communities throughout the state where all children, youth and families are valued, and have access to quality inclusive child care offered by providers who are fully supported by coordinated resources from all sectors of society.	To increase access to quality inclusive child care and out-of-school care for children and youth throughout the state of Washington.

Map to Inclusive Child Care National Institute



August 12-13, 1999
Washington, DC

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Washington	We envision communities throughout the state where all children, youth and families are valued, and access to quality inclusive child care offered by providers who are fully supported by coordinated resources from all sectors of society.	To increase access to quality inclusive child care and out-of-school care for children and youth throughout the state of Washington.

Meetings

Several groups of people met on a regular basis to review the progress of the EZ-PIP project. Regular staff meetings were held, advisory group meetings, mentor support group meetings, and center director meetings. Attached are sample agendas and minutes.

- **Staff**
- **Center Director**
- **Mentor Support Groups**
- **Advisory Board**

The Enterprise Zone - Preschool Inclusion Project

Staff Meeting

February 16, 1998

Welcome

NEC TAS Visit
    Impressions

The Governor's Children's Summit

What do we do now?

    Research Component Report - Scot Liepack

    Center Component Report - Faye Farnsworth

    Family Child Care Component Report - Michele Scott

Grant Performance Report for Continuation

Access Training

Additional Information

Closing
    Next meeting

Enterprise Zone-PreSchool Inclusion Project Minutes

Center Director's Meeting
May 24, 2000

Attendance: *Sheena Benjamin-Wise, Project Manager; Blynda Murray, Assistant Project Manager; Tamar Laborde, Project Staff Assistant; Bertha M. Alexander, Randolph's Kiddies Inn; Shirley Sparks, Nicole Sparks, Sparks Day Care; Abbie Mitchell, Allapatthah-YMCA; Mary Perkins, Earlene Dorsett II (E.D. A. II); Gwendolyn Gourdet, Earlene Dorsett & Annex I (E.D. A. I); Adrianna L Munguia, Holy Comforter Day Care; Gladys Montes, MDCC- Center for Early Care & Education.*

Sheena opened the meeting by introducing the staff, than provided a video presentation:
I am Your Child- Quality Child Care: Making the Right Choice for You and Your Child.

Project Progress

- All D.O.C.S should be turn in by September before next school year starts:
- Certificates of attendances and certificates of completion were distributed at the last session on April 12, 2000.
- Currently, there is one mentor/mentee (teacher) relationship established unfortunately this relationship will change because the mentor is relocating to Orlando. They decided to still keep in touch for further assistance.
- NAEYC accreditation program is available for the centers, reimbursement is available upon request .

Summer Training

- There will be a Summer Mini Course from June 8 – July 13 at 5:30 – 8:00pm, dinner will be serve for those who arrive on time.
- Session will be at the Mailman Center for Child Development on the 4th floor fishbowl.
- They are six sessions instead of twelve; however, will discuss different strategies.
- All teachers, child care providers, and center directors are invited to the training sessions.

Special Instruction Services

- Kenny will no longer serve the centers as a SIC Consultant in the fall.
- Abbie Mitchell, center director assistant at YMCA- Allapattah has three children with concerns (speech delay). Kenny is in the process of contacting Hearing & Speech for evaluation.
- Ms. Mary Perkins & Ms. Gwendolyn Gourdet from E.D.A. I & II have not yet met Kenny.
- Ms. Nicole Sparks from Sparks Daycare will contact Kenny for Speech & Hearing follow up.

Discussion

- Gladys Montes from MDCC-North Pre-school is concern about the other center directors are so disperse. She suggested that we should meet more often to discuss their problems and solutions among themselves.
- She also mentioned to have center directors open circle or a round table.
- Sheena and the Center directors agreed on having an open circle as of October.
- Sheena is leaving EZ-PIP as of May 2001.

Enterprise Zone- Preschool Inclusion Project

Center Director's meeting

May 24, 2000

Administrative Inclusion Materials

Video Presentation

I am Your Child - Quality Child Care:
Making the Right Choice for You and Your child

Project progress

- Date collection: DOCS Packets
- Training April - Certificates of Attendance and Certificates of Completion
- Mentors (Teachers)
- NAEYC Accreditation program

Summer Training

Special Instruction Services

- Child needing services

Legislative Update

Next meeting –

2/18-20/98 FF--draft

Enterprise Zones-Preschool Inclusion Project
(EZ-PIP/CCCs and FCCHs)

MINUTES

Monday, February 16, 1998
1:00 p.m. to 4:00 p.m.
University of Miami's Mailman Center for Child Development (MCCD)

Mailman Center for Child Development in Attendance:

Susan Gold, Principal Investigator, EZ-PIP
Sheena Benjamin-Wise, Project Manager/PIP
Faye Farnsworth, Project Manager, EZ-PIP/CCC
Michele Scott, Project Manager, EZ-PIP/FCCH
Scot Liepack, Research Coordinator, EZ-PIP
Elizabeth Otto, Research Assistant, EZ-PIP
Louise Marcelin, Research Assistant, EZ-PIP
Yuly Borroto, Research Assistant, EZ-PIP
Rhonda Conway, Mentor Consultant (in absentia)

TOPICS OF DISCUSSION

I. Welcome and Updates

Susan Gold, Ed.D., opened the meeting. She asked the staff for their impressions of NEC*TAS' (National Early Childhood Technical Assistance System) February 10 and 11 meetings with Joicey Hurth and Mary Shields concerning the development of our model demonstration project.

In summary: Intense! Exhausting! Enlightening! We agreed that we have a better overall understanding of the project. We can build our new time line in monthly increments. The staff will work together to reach consensus on our model.

The Governor's Children's Summit in Orlando, FL, was February 12. Susan Gold, Sheena Benjamin-Wise and Michele Scott attended. Two of the three sessions Sheena went to were "Domestic Violence" and "Early Intervention Program." On the latter, research is now showing that a 3-year-old child of an educated mother has the vocabulary of an uneducated adult.

Michele's main purpose was to maintain and develop contacts. She attended sessions on the "Readiness Project" and the "Resourcemobile" (the latter presented by Ana Colon who is participating in our Mentoring Training program).

Michele learned that Anita Bock of the State of Florida's Department of Children and Families Services (CFS) is redesigning the procedures in which children are removed from their homes to foster care based on the CFS's Life Zones (the boundaries of which vary from federal "empowerment zones" and municipal "enterprise zones"). Additionally, Michele discussed the FCCHs with Anita and sent her information on the state of the art in Miami-Dade County.

Catherine Kamiya, chair of the ~~[illegible]~~ FICCIT Council (Florida Interagency Coordinating Council for Infants and Toddlers), discussed at a session attended by Michele putting together a summer intensive project for Child Development Associate (CDS) credentialing most for Head Start. Additionally ~~[illegible]~~ FICCIT is looking into a mentor project. Michele referred her to Murial Wong Lundgren.

In addition to meeting Governor Lawton Chiles, Michele met with two CFS representatives: Secretary Ed Fever and Linda Radigan (who is Larry Pintcuda's boss) and United Way's Executive Director Ted Granger.

As a result of Susan Gold's meeting with Tallahassee's Mimi Graham at the summit, Susan received a call from Mimi expressing interest in responding to a federal RFP (request for proposal) on the issue of inclusion in the panhandle. Mimi wants to bid on federal funds but does not want to be "in competition" with us. Susan assured her that that would not be the case. Mimi was interested in reviewing our EZ-PIP model demonstration proposal. Susan recommended that she contact the State of Montana as their model would more likely match Tallahassee's needs as opposed to multi-cultural Miami-Dade County.

PROFILE Training--No update. *TULIP*, V.1, N.2--No update.

II. Research Update

Scot Liepack addressed the "what do we do now?" question.

Our model project can be adjusted to optimize outcomes. Unlike other model demonstration projects, we have a control group in our research and service design.

To get things up and running, Scot will develop a short-term time line. Questions on when will we know we are ready to leave Homestead were brought up.

At Susan Gold's directive, Scot Liepack will secure bids for ACCESS (our data base) two-part trainings. Follow-up technical assistance will be priced. Copies of Micro Group's newsletter were presented which offers training. Questions posed were about (l) support within the Mailman Center; (2) where training will be held, (3) Calder Library and (4) working out group and specific training for us.

The web site is in progress.

III. Child Care Centers Update

Faye Farnsworth is scheduled to give an initial presentation Tuesday, February 24, beginning at 12 noon to Anita Johnson and her staff at Prodigy Child Development Center of Florida Power and Light in Homestead. Yuly Borroto will assist.

Seventy-three staff from nine centers have already attended our initial presentations. We expect 12 participants from Prodigy (our tenth center) bringing the total number to 85 prospective participants.

Susan gave the directive to make plans for data collection and to go forward with random assignments.

The first step will be to set a meeting for nine of the ten center directors in the Homestead area. (Notations: Small World Day Care has withdrawn and there have been no responses to our February 6 mailing to 25 additional centers.) At the meeting, we will:

(1) give an overview of our model demonstration project (i.e., its design, implementation and potential outcomes);
(2) ensure each director knows his/her commitment;

(3) ensure each director knows of his/her staff's commitment;
(4) explain random assignment (why and its importance);
(5) explain experimental group vs. c~~ontrol~~ Training only group
(6) explain complimentary training in first year for other than control group sites
(7) emphasize the confidentiality of participants
(8) explain the mentoring process
(9) encourage center directors to be nonjudgmental of staff who decline to participate.

Discussion ensued on how the random assignments would be made. Following is a more detailed picture of the process as seen by Faye at the time of transcription of minutes.

Our Year 1 goal is to select 30 English-literate center directors, assistant directors and teaching staff who work a minimum of 80 hours per month to be included in our experimental group; 30 English-literate center directors, assistant directors and teaching staff who work a minimum of 80 hours per month to be included in our control group; and the remaining (approx. 20-25) English-literate center directors, assistant directors and teaching staff who work a minimum of 80 hours per month to receive complimentary training unless they work at a control site which would render them ineligible for training in Year 1.

No center will have a Training only **mix of experimentals and controls**. A center will be designated as either an experimental site or a c~~ontrol site~~. ~~If a control site has reached our quota and has remaining staff not~~ selected, ~~the remaining staff will not be eligible for complimentary training in Year 1~~. ~~However, if~~ an exper~~imental site has reached our quota and has remaining staff not selected, the remaining staff will be~~ eli~~gible for complimentary training in Year~~ 1.

After our Center Directors meeting, we will begin random assignment by putting the names of all participating centers in a "hat." A neutral party will draw the first slip and that center will be labeled No. 1. A second slip will be drawn and labeled No. 2. This procedure will continued until all slips have been drawn and numbered. Faye will then begin calling the centers and secure a complete list of all directors, assistant directors, teachers, teacher assistants and teacher aides. Site visits will begin to be scheduled in the order of the draw. Faye and two research assistants will make site visits beginning with Center No. 1 to secure signed consent forms from each person listed. A determination by the site visit team will be made at that time as to whether or not each person signing the consent form is eligible (e.g., an English-literate employee [center director, assistant director, teacher, teacher's assistant and teacher's aide] who works a minimum of 80 hours per month).

The 30 slots in the experimental group will be determined first. For example, if Center No. 1 has ten employees and five are eligible, Center No. 2 will be visited. If Center No. 2 has 30 employees and 27 are eligible (an overage of two people), the center director will be automatically included. The remaining 26 names will be written on slips, the first two names drawn will be eliminated from the experimental group but will be offered complimentary training in the first year.

The 30 slots in the control group will be determined after the experimental group is selected. The same procedure would take place; however if there is an overage, the staff eliminated from the control group would not be offered nor receive complimentary training in Year 1.

If we are unable to fill 60 slots, we will begin recruiting additional centers by randomly assigning numbers from 1 to 25 to the 25 centers on our February 6 letter mailing list. Center 1 will be called by Faye and offered an orientation. Depending upon their response, Center 2 and so forth may be called. The random selection process will immediately follow the orientation as deemed necessary.

At this writing, scheduling the Homestead Center Directors' meeting in the Chamber Hall of Florida City's City Hall has resulted in the following:

Thursday, February 26 at 1:30 p.m.: 4 yes, 7 no, 1 will call back. (Chamber Hall has a 4:30 booking; however our staff could adjourn to their 8-10 person executive conference room for a debriefing.)

Monday, March 9 at 9:30 a.m.: 6 yes, 4 no, 2 will call back. (Following our 1:30 p.m. mentor training at Bet Shira our staff could have a debriefing.)

Tuesday, March 10 at 9:30 a.m.: 7 yes, 3 no, 2 will call back. (Chamber Hall booked at 12 noon; however, our staff could adjourn to their 8-10 person executive conference room for a debriefing.)

It appears two meetings will be necessary--March 9 and 10. The Chamber Hall has been reserved for those two mornings.

Directors available March 9 are:

1. Elena Guerra of Small Wonders*
2. Julie Borgis (newly appointed director of LeJardin's Site 5 replacing Arlynn Quinnones)*
3. Anita Johnson of Prodigy@FPL*

4/5. Idania Lemus* and Barbara Griffin (newly appointed director replacing Susan Garcia) of Homestead Nursery

6. Peggy Johnson of YMCA.

Directors available for March 10 are:

1. Elena Guerra*
2. Julie Borgis*
3. Anita Johnson*
4. Idania Lemus*

5/6. Regina Hudson and Aquilla Lee of Hudson,

7. Verna Yapp of Kids-R-Ific

The asterisk (*) denotes available either date.

Dedrain Arance of LeJardin Site 4 and Joyce Outer of Eighth Street School have not responded. [Note: Ed Berrones of LeJardin is not available to attend. His office is confident that Site 5 Director Dedrain Arance will be available March 9 and/or 10.]

Ron Muscarella's assistant, Louis Dilan, cleared Ron's calendar for March 9 and 10. The Chamber Hall has theater-style seating for 25. It has no overhead projector. There is a side "hospitality" table *sans accouterments*. Peggy Johnson will lend her 24-cup coffee pot with ground coffee for both days. We'd need creamers, sugars, stirrers, disposable cups, napkins and tablecloth plus breakfast snacks.

IV. Mentoring Update

No formal report from Rhonda. At the time of transcription, Faye notes the following:

February 23 is our fourth of eight training sessions. In a follow-up call Faye to Sandra Kolonais of KIDCO, who has missed Session 2 and 3, Sandra is unable to continue the mentor training. Also, Carol Byrd our special instruction consultant (SIC) from UCP is unable to continue mentor training due to a conflict in schedules. She is returning her copy of our training manual by mail to Faye for recirculation.

An update on the three training session attendance:

- Four of the eight MCCD have attended all three; four have attended two.
- Four of the six center directors have attended all three; two have attended two.
- Six of the seven teachers have attended all three; one attended one session and has withdrawn.
- None of the two SICs has attended all three; one attended two sessions; the other attended one and has withdrawn.

RECAP: Of the original 23 prospective mentors, two (2) have withdrawn leaving 21 prospective mentors. Of those 21 prospective mentors, 14 have attended all sessions; seven (7) have attended two sessions.

V. Family Child Care Homes (FCCH) Update

Michele Scott's newsletter, *AT HOME WITH FAMILY CHILD CARE*, Vol. 1, No. 1, is at press. While CDS will mail copies of her newsletter to all 266 licensed Family Child Care providers, only the providers listed within the Homestead Enterprise Zone will receive the flyer recruiting FCCH providers for inclusion training.

The first-year goal is to recruit 15 providers who will receive the complimentary "Second Helping" curriculum. Unit 1 of the curriculum must be given first; however, the remaining units can be given in any order. Michele will oversee delivery of the curriculum. There will be no control or experimental group in this component of our model. Michele is identifying the FCCH providers by zip codes in Homestead.

Licensing issues facing providers are the $1,400 zoning fee and $50 fire department inspection fee.

VI. NEW BUSINESS

Our grant performance report to the U. S. Department of Education's Office of Special Education Programs (OSEP) is due March 20, 1998. The reporting period is October 1, 1997 through February 20, 1998. We will be reporting on the 12 objectives of our six goals (see p. 14 of the grant).

Susan Gold assigned staff to submit draft summaries on their respective objectives (as noted below) by Monday, March 9:

Objective 1 **(Scot)**--Document the needs of young children with disabilities in target communities.

Objective 2 **(Michele)**--Expand the center-based PIP model to include FCCHs and implement the model in the Enterprise Zones.

Objective 3 **(Susan and Sheena)**--Establish a plan for recruiting children with disabilities in EZ-PIP CCCs to ensure 260 children are served by the end of the project.

Objective 4 **(Faye)**--Provide specialized training on disabilities and serving children in natural environments for CCC providers.

Objective 5 (**Susan**)--Provide structured mentoring framework for all EZ-PIP participants.

Objective 6 (**Susan**)--Implement and expand the SIC services to ensure progress of children with special needs.

Objective 7 (**Faye**)--Increase the quality of CCC sites (e.g., NAEYC).

Objective 8 (**Faye**)--Provide support and education for parents and encourage parent participation (N/A at this time--in development).

Objective 9 (**Susan**)--Facilitate cooperation among the existing systems of service delivery for children with disabilities.

Objective 10 (**Scot**)--Evaluate the model according to the eco-systemic framework.

Objective 11 (**Faye**)--Provide for the replication of the EZ-PIP model (e.g., keeping detail records gathering information, and building training guide).

Objective 12 (**Susan**)--Dissemination of the project model and research findings (N/A at this time--staff will be presenting findings through presentations, papers and articles for publication).

VII. Calendar

Monday, February 23, 1998

EZ-PIP Fourth Mentor Training Session @ Bet Shira's Library
"Adult Development; Reflective Practice"
1:00p-3:00p (brown bag lunch)

Monday, March 9, 1998

First Homestead EZ-PIP/CCC Center Directors' Meeting **TBC** @ Florida City's City Hall in the Chamber Hall
9:30-11:30 a.m. w/ Host Ron Muscarella, director of housing and economic development

EZ-PIP Fifth Mentor Training Session @ Bet Shira's Library
"Communication: Giving & Receiving Feedback"
1:00p-3:00p (brown bag lunch)

All Staff Meeting (debriefing) TBC @ Bet Shira Library following Mentor Training

Tuesday, March 10, 1998

Second Homestead EZ-PIP/CCC Center Directors' Meeting **TBC** @ Florida City's City Hall in the Chamber Hall
9:30-11:30 a.m. w/ Host Ron Muscarella, director of housing and economic development

All Staff Meeting (debriefing) TBC in Executive Conference Room of Florida City City Hall following Center Director meeting

Monday, March 23, 1998

EZ-PIP All Staff Meeting 10:30a-12:00n **TBC** @ S. Dade Location **TBA**

EZ-PIP Sixth Mentor Training Session @ Bet Shira's Library
"Advocacy/Leadership; Guest Speaker"
1:00p-3:00p (brown bag lunch)

Monday, April 13, 1998

EZ-PIP All Staff Meeting 10:30a-12:00n **TBC** @ MCCD **TBA**

EZ-PIP Seventh Mentor Training Session @ **MCCD TBA**
"Mechanics and Tools of Successful Mentor Protege Relationships"
1:00p-3:00p (brown bag lunch)

Monday, May 4, 1998

EZ-PIP All Staff Meeting 10:30a-12:00n **TBC** @ S. Dade Location **TBA**

EZ-PIP Eighth Training Session--final 4 hours @ Bet Shira's Library
"Pulling It All Together; Certificates"
9:30a-1:30p (brown bag brunch)

Distribution of Minutes to MCCD Staff:
Susan Gold, Ed.D.
Sheena Benjamin-Wise
Faye Farnsworth
Michele Scott
Scot Liepack
Elizabeth Otto
Louise Marcelin
Yuly Borroto
Rhonda Conway [FAX 971-9095 or E-Mail rhoncon@aol.com]

Enterprise Zone- Preschool Inclusion Project

MENTORING SUPPORT MEETING

November 17, 1997

Greetings/ Introductions/ Welcome

NAEYC Conference Review

- EZ-PIP Project Update
    - Research Instruments-Scot Liepack
    - Family childcare homes-very active support-Michele Scott
    - Introduced the Family childcare flyer
    - Homestead School Participant list-Faye Farnsworth
    - Discuss EZ-PIP 89 page brochure
- Adoption of minutes
- Mentoring Component Update Information-Rhonda Conway
- Open Discussion/ Q&A
- Introduce "The Tulip" newsletter
- Distribute Calendar
- Next Meeting

11/18/97 rev 12/4/97/SG/FF

Enterprise Zone-Preschool Inclusion Project (EZ-PIP)
Second Mentor Planning Meeting

Monday, November 17, 1997
1:00 p.m.-3:00 p.m.
Bet Shira's Library; 7500 S. W. 120 Street; Miami, FL 33156
Telephone: 238-2606/5706

Mailman Center for Child Development:
Susan Gold, Ed., Principal Investigator, PIP and EZ-PIP;
Sheena Benjamin-Wise, Project Manager, PIP (in absentia);
Faye Farnsworth, Project Manager, EZ-PIP/Child Care Centers (CCCs);
Michele Scott, Project Manager, EZ-PIP, Family Child Care Homes (FCCHs)
Scot Liepack, Research Coordinator, PIP and EZ-PIP (in absentia)
Elizabeth Otto, Research Assistant, EZ-PIP
Louise Marcelin, Research Assistant EZ-PIP

Mentors:
Claudia Gray (Center Director, Elizabeth Curtis CCC)
Peggy Johnson (Center Director, Homestead Family-YMCA)
Susan Rosendahl (Center Director, UM*Canterbury) (in absentia)
Gladys Montes (Director, Catholic Community Services) (in absentia)
Yolanda Borroto (Center Director, South Miami Lutheran) (in absentia)
Rosemary Moreno (Center Director, REM Learning Center) (in absentia)
Terri Reynolds (Teacher, Bet Shira CCC)
Nancy Feldman (Teacher, formerly with Brickell Christian)

Consultants:
Rhonda Conway, (Conway & Associates, Inc.), Mentor Consultant
Pat Donovan, (ARC) Special Instruction Consultant (in absentia)
Carol Byrd, (UCP) Special Instruction Consultant (in absentia)

TOPICS OF DISCUSSION

I. Introductions and Welcome

Susan Gold began the meeting by introducing our two new research assistants, Elizabeth Otto and Louise Marcelin.

Joined by our host (Judi Gampel, director, Bet Shira) we each introduced ourselves. Judi, having just returned from the National Association for the Education of Young Children's (NAEYC) annual conference in Anaheim, CA., shared an inter-office staff memo highlighting the sessions she attended (three on inclusion). She provided a handout on the "Early Childhood Staff Working Together to Create Inclusive Classrooms: A Learning Team Approach" by Penny Wald of George Washington University and Holly Blum of the Fairfax, VA, County Public Schools. Judi has graciously offered to put together a presentation highlighting the conference's session she attended.

Before turning the meeting over the Rhonda Conway, Susan Gold gave an update on the rest of the EZ-PIP project:

She and Scot Liepack are preparing for their DEC conference presentation in New Orleans, November 22, 1997.

After the DEC conference, Scot will focus his energies on the UM Internal Review Board's (IRB) review of our research instruments. Faye Farnsworth, in collaboration with Sheena Benjamin-Wise, Elizabeth Otto and Louise Marcelin, will begin developing the 60 to 64 additional pilot pre/post questions for IRB review December 3 and 4.

Michelle D. Scott, is meeting with Metro-Dade Office of Community and Economic Development's (OCED) Ignacious De La Campo's assistant, Tuesday, November 18, 1997, to gain active support for the Family Child Care Homes (FCCH) component of the EZ-PIP grant.

Michelle has prepared a letter of intent to the Dade Foundation and is preparing two proposals (state and national conferences).

Additionally, she presented the first draft of the EZ-PIP/FCCH one-page flyer for distribution in December.

Faye Farnsworth gave an update on the nine participating child care centers in the Homestead area. An on-site visit to each center is pending. Faye will confer with Peggy Johnson to begin scheduling training dates (tentatively for the end of January or beginning of February). Enthusiasm is growing among early childhood educators for training to begin. Simultaneously, we will begin English-speaking training at our North Creole Site (YWCA) at the request of their center director. The "Y" is a PIP site and we need to keep data collection free from contamination; so we will go outside the Homestead enterprise zone area in Year 1. Additionally, Claudia Gray advised that Sparks Day Care and Kindergarten in North Dade is interested.

The first draft of the 8-page EZ-PIP/CCC brochure was discussed. A first read looks very positive and the brochure is off for committee review.

II. Adoption of Minutes

Rhonda Conway made two corrections to the October 15 minutes:

Page 2, IV. Recruitment of Proteges, No. 3: "leadership training for mentors is required before pairing occurs" and

Page 2, V. Training: Who? When? Where? First paragraph, second sentence: "It is proposed mentors receive a modest stipend to defray their out-of-pocket costs...."

III. Mentoring Component

Rhonda Conway led the discussion by submitting a draft of the suggested protégé teacher application packet which will be adapted for the center director mentor packet. The packet is being reviewed.

Rhonda brought up the subject of marketing for mentors. Susan Gold discussed the grant's budget limitations where there is funding for four mentors in each of the four years of the grant so that marketing for more mentors at this point, without additional funds, was not a real concern.

(The group put forth recommendations for mentor funding sources such as the South Dade Women's Council of Realtors, the National Council of Jewish Women, Resources for Children [Dr. Wil Blechman's organization], the Kellogg Foundation and Pillsbury.)

Rhonda highlighted the following areas of consideration:

1. How many center directors and teachers can each center director mentor and teacher mentor handle?

2. Time availability of mentors and protégés. The current budget allows stipends for four mentors at three hours each per week.

3. A mentor survey will include questions such as where they live and work. [Note: Rhonda will coordinate with Scot Liepack on any data collection.]

4. For the FCCH component, Michelle Scott will be the mentor to all FCCH providers.

5. Urged getting center directors totally invested in mentoring program to effect the "trickle down" effect. Strong leadership evokes a strong following.

IV. Open Discussion

Terri Reynolds reports that since our October 15 meeting, three teachers (to her surprise and delight) approached her asking for inclusion support. She found Rhonda's handouts from that meeting to be helpful in answering their questions.

Peggy Johnson's staff is anxiously awaiting inclusion training. And Claudia Grey is experiencing similar positive feedback.

Susan Gold, in looking back at the old data from PREP, noted when center directors came to meetings, there was higher teacher attendance. Further, it took about one and a half years after initial inclusion training that significant positive changes in the centers were noted.

Susan reminded the group on the importance of center director mentors not mentoring their teachers due to the supervisory nature of their positions. She also encouraged the evolution of cross-school mentoring.

Hot-off-the-press copies of our newsletter, **The TULIP**, were distributed. Susan will be preparing an article for the second edition on mentoring.

Invited to this meeting as new center director mentors were Rosemary Moreno, Gladys Montes and Yolanda Borroto. Their schedules did not permit attendance at today's meeting. Pat Donovan and Carol Byrd, our Special Instruction consultants, will be present once our mentor training sessions begin in January 1998.

Susan debriefed the group on her October visit to the White House announcing the Clinton Administration's initiative on early childhood development.

On November 20 there is an open meeting at *The Miami Herald's* office where Governor Lawton Chiles' initiative on early childhood education will be put forth by David Lawrence, publisher. A discussion of readiness for school will bring forth a stinging indictment on the woeful lack of support to the early childhood education field by way of prestige and wages.

The Dade County Public School Board meets on December 10 at 10 a.m. at their 1500 Biscayne Offices to discuss early childhood education issues--Goal I: Are children ready to learn? This is a long-term proposition being considered by this newly appointed board.

V. Calendar of Eight Mentor Training Sessions

1. Monday, January 12, 1998
9:30a to 1:30p
(first meeting--4 hours)
Bet Shira's Library*

2. Monday, January 26, 1998
1:00p to 3:00p
Bet Shira's Library*

3. Monday, February 9, 1998
1:00p to 3:00p
Bet Shira's Library*

4. Monday, February 23, 1998
1:00p to 3:00p
Bet Shira's Library*

5. Monday, March 9, 1998
1:00p to 3:00p
Bet Shira's Library*

6. Monday, March 23, 1998
1:00p to 3:00p
Bet Shira's Library*

7. Monday, April 13, 1998
1:00p to 3:00p
(Place of Meeting to be Confirmed)
YWCA-Gerry Sweet Center*; 351 N.W. 5th Street
377-9922
OR
UM Mailman Center for Child Development*
1601 N.W. 12th Avenue; 4th Floor Conference Room
243-6624

8. Monday, April 27, 1998
9:30a to 1:30p
(final meeting--4 hours)
Bet Shira's Library*

*It was suggested we have a "bring-your-brown bag" lunch.

Distribution of Minutes to:

MCCD Staff: Susan Gold, Ed.D.
Sheena Benjamin-Wise
Faye Farnsworth
Michele D. Scott
Scot Liepack
Elizabeth Otto
Louise Marcelin

Mentors: Claudia Gray, FAX 305-633-3940
Peggy Johnson, FAX 305-248-5193
Susan Rosendahl, FAX 305-662-1615
Gladys Montes, FAX 754-6649
Yolanda Borroto, FAX 305-661-4062
Rosemary Moreno, FAX 305-235-0007
Terri Reynolds, FAX 305-238-5706
Nancy Feldman, FAX 305-595-4077 (call first)
Blynda Murray, FAX 248-5193

Consultants: Rhonda Conway, FAX 305-971-9095
Pat Donovan, FAX 754-9223
Carol Byrd, FAX 325-1313

File: MCCD:PIP (Year 3) 11/17/97 Mentor Minutes; and
MCCD:EZ-PIP/CCC & EZ-PIP/FCCH (Year 1) 11/17/97 Mentor Minutes ✓

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The Preschool Inclusion Project

&

EZ-Preschool Inclusion Project

Advisory Committee Meeting
March 11, 1998
AGENDA

I. Lunch served

II. Introductions and approval of Minutes

III. Update on PIP Training
    Training
    Research
    Special Instruction Consultant

IV. Enterprise Zones - Preschool Inclusion Project
    NEC TAS visit
  EZ-PIP Components
      Research-
      Training Programs
        9 Child Care Centers-Homestead
        Family Child Care Homes
        Mentoring Program

V. Upcoming Conference
    Save the Children Conference

VI. At Home with Family Child Care

VIII. Confirm next meeting May

The Preschool Inclusion Project (PIP) and
The Enterprise Zone- Preschool Inclusion Project (EZ-PIP)
Advisory Committee

March 11, 1998
12:00 p.m.
University of Miami - Mailman Center for Child Development

MINUTES

In Attendance:

Bader-Tables, Roni - DCPS Pre-K
Benjamin-Wise, Sheena - MCCD
Colon, Ana A. - Miami-Dade CDS
Garcia, Isabel - Parent-to-Parent
Gold, Susan - MCCD
Hernandez, Iliana - FDLRS
Laney, Rosalyn - Family Central
LaLinde, Paula - MCCD
Masvidal, Adriana Diaz - Econ. Opportunity
Moreno, Rose Mary - REM Learning Center
Paied, Ginny - Paradise Christian Schools
Platt, Anita - Family Central
Scott, Michele D. - MCCD
Watson, Howard - Dept of Labor WAGES

Topics of Discussion

I. Lunch served

II. Introductions and Approval of Minutes

The minutes were distributed for review and approval was given to accept the minutes.

III. Update on the Preschool Inclusion Project Training

Training: Sheena Benjamin-Wise informed the committee even though the PIP is in the final year, centers are still requesting training. She is having to tell centers unless they are in specific area, Enterprise Zones, they can not receive the training next year. There are funding options being explored in order to offer training to private child care centers without cost. The fact that the centers still want to receive the training is very encouraging. There are over 200 participants that have received the PIP training, to date. The last co-hort is just about ready to graduate.

Sheena Benjamin-Wise presented a copy of the Early Childhood Association journal Dimensions which includes the article written by Dr. Gold, Scot Liepack, Sheena-Benjamin Wise and Michele D. Scott, *If You Offer Inclusion Training, They Will Come!* Roni Bader-Tables commented on the layout of the article and the text box which listed the titles of the 13 training sessions. She found this very informative.

Special Instruction Consultant: Sheena Benjamin-Wise reported there is now a speech pathologist working at one of the PIP centers for on-site therapy and she is trying to arrange for another school to receive these services. She was questioned and discussion followed as to whether this was covered by Part H or not and if the provider was bi-lingual

IV. Enterprise Zones- Preschool Inclusion Project

NEC TAS: Dr. Susan Gold presented the results of a visit from two representatives from the National Early Childhood Technical Assistance System. This group is part of the University of

North Carolina in Chapel Hill, in association with the Zero to Three organization in Washington, whose function is to offer technical assistance to groups that have received grants from the office of Special Education. They were here for several days to help us conceptualize the project we are funded for and left us with a working model of our effort. Their Model Development 101 course explanation was given, with the conclusion that this is a model development project. This means we began with a problem and will attempt to show a solution. A model development project is a promise we are making to the Enterprise Zones to offer assistance with the problem we have defined. Our objective is to increase the availability of quality inclusive child care centers and family child care homes to be better able to serve the children in their own neighborhoods. Each of the various aspects of the project were outlined briefly and the participants roles were explained. After Dr. Gold's presentation the committee requested copies of the overheads after the necessary changes due to name changes, etc. have been made.

EZ-PIP Components: Training Programs

Child Care Centers: Susan Gold reported on the first Center Director's meeting held yesterday in Florida City, at the satellite office of the Office of Economic Opportunity. Every child care center in the five zip code area had been sent an invitation to participate and initial presentations were made to those sites that responded. At the initial presentations, they were provided with the details of the project and asked to consider their ability to make the commitment to the project. Those Director's attending the Center Director's were then asked to complete the informed consent which is their promise to stay with the project, encourage their staff to participate and to allow us to conduct the training and collect data. The consent forms for the participating teachers will be sent to the staff at the schools represented at this meeting.

Assessments will be conducted prior to the training beginning and we hope to begin the training in the next few weeks. Sheena Benjamin-Wise explained the difference between PIP and EZ-PIP in that the number of centers and teachers we will be working with will be much smaller. We anticipate working with approximately thirty centers during the three years of the project, beginning with nine child care centers in Homestead.

Sheena Benjamin-Wise continued explaining the Inclusion Curriculum and the Tentative Schedule of Sessions which were part of the handouts. Along with the sessions used for PIP, there have been sessions added to this curriculum on brain research, and how to conduct screenings. She also reported there are training sessions currently being developed for the Center Director's. We want to use the Center's Directors meeting time for more than the support group that was part of the PIP. Eventually, we would like to see a training developed for the parents as well. The time of day these meetings will be held will be determined by the centers and parents to meet their needs.

Some additional concerns were discussed on the issues of transportation and trying to keep the children with the same teacher during the training year. Roni-Bader Tables requested to see some of the modules, especially the videos, in order to be able to contribute or share in the information presented. It was suggested the video mentioned could be viewed prior to or part of the next committee meeting. The Advisory Committee was reminded they may attend any of the training sessions being offered and called their attention to the schedule attached..

Responding to a question from one of the members, Susan Gold spoke about the pending state mandate to conduct school readiness screening on all children using either the Brigance or the Ages and Stages instruments. Scot Liepack then presented information on one of the research components of the assessment package being used in the EZ-PIP, the Developmental Observation Checklist System (DOCS), recommended by Dr. Bagnato. He stated as a consideration for using this particular screening instrument, the teachers could benefit from using the results as a learning tool for observing children. This instrument has been ordered and will be available for the committee to review at the next meeting. Susan Gold stated she has been speaking with Pernella

Burke regarding the county's ability to select an instrument other than those mentioned by the state. It was further explained we ideally would want to use the same instrument in our project that Miami-Dade will be using to conduct the required screenings. The final determination has not been made and does depend in part on the availability of funding from the state level to implement the screening. Our interest in this topic is based on the consideration that EZ-PIP will potentially be working with 180 early care and education classrooms. The number of children that could potentially be screened through our project is 12-1500, making this a respectable number for research purposes.

Family Child Care Homes: Michele D. Scott presented information on the status of the Family Child Care newsletter, *At Home With Family Child Care*. It has been printed and is on its way to the providers. Additionally, she reported a separate flyer announcing the project was sent with an invitation to participate to all the providers in the Homestead zipcode area. There will be more of the need to work one-on-one with the family child care providers and it is understood it will probably require a follow up phone call as well.

Michele Scott informed the committee of her intention to adapt the PIP curriculum for family child care and that the "There's No Place Like Home" curriculum from Wheelock college has been purchased. This training material is topical, can be tailored to the individual, and has homework assignments that can be left with the provider. She also related that the homework is also in Spanish which will be very helpful with this population. Ana Colon has indicated she would be available to assist with the Spanish providers.

Mentoring Program: Dr. Gold asked Rosemary Moreno if she would describe the most recent mentoring class. She spoke about the role play exercises and the insight she has gained from attending these classes. Susan Gold continued with an overview of the mentoring program, including information about the reflective practices being explored through the journal writing that the students are required to maintain. The student-mentors are writing about their experiences as a child care teacher or a center director. This practice will continue on throughout the course with the journals being turned in to be reviewed by the instructors, Muriel Wong Lundgren and Rhonda Conway. Mentors will then be paired with protégés and the journal writing will be continued by both. The journal writing will be an important piece in our project because it will be the documentation of the effectiveness of our inclusion training.

Susan Gold then explained about our intention to promote collaboration in the neighborhoods between the child care centers and the family child care homes. This collaboration is intended to demonstrate the effectiveness of the progression from a smaller early care environment to a larger child care center setting. It should help to ease the concern of putting infants and very young children into child care centers and allow another quality alternative to parents of children with special needs who may function better in a small group setting.

V. Upcoming Conference

Save The Children: Sheena Benjamin-Wise reported she will be presenting this project at the National Family Child Care Technical Assistance Conference held in Atlanta, GA. She also stated this will be her formal introduction to the field of family child care, and is looking forward to receiving information from all over the country.

VI. At Home With Family Child Care

The newsletter for family child care providers in the Miami-Dade county area was distributed for the committee members to review. The bright yellow newsletters are being sent to providers at this time.

VIII. **Next Meeting: The next meeting will be held Wednesday, May 27, 1998.**

VIX. Announcements: Dr. Gold announced we have recently received word that we have been awarded a grant from the Dade Community Foundation to conduct a recruitment, orientation and training program for family child care providers. This program will work in cooperation with the state's Child Care Initiative and Miami-Dade Child Development Services, based on their commitment to increase the number of family child care providers in the county. The office space at the Office of Economic Opportunity will be used for this project

Susan Gold also spoke about the Statewide Strategic Planning Workgroup for Inclusion being sponsored by the Developmental Disabilities Council. This group, facilitated by Susan Mackey Andrews of Maine, held their first two-day meeting in Tampa recently. The purpose of bringing together from throughout the state, members of different groups for children with special needs is to develop a written strategic plan of meeting these needs by analyzing what is currently available. There are many different agencies represented on this workgroup, some on a higher state level who have not been present before. The understanding of the D.D. council is while no one organization can provide all the services, allowing for each agency to bring what they are doing to the meeting will help focus on what is still needed.

There was a brief discussion on the need for after-school arrangements for children with special needs. Several members commented on their experiences and knowledge of programs. After-school programs as part of various elementary schools and Parks and Recreation were mentioned directly as was a program in the Coconut Grove area being run by Annie Hoover. Members were advised to be aware of programs that might be of interest to others.

Ana Colon announced Miami-Dade Child Development Services will be holding their annual Health Fair at the Seaport on Wednesday, April 29, 1998. This is a big event with clowns and other entertainment as well as educational interests. FDLRS will be conducting screening for children and it was suggested that involvement from the Mailman Center for Child Development be considered due to the anticipated large turnout. Ana Colon explained the way the event is designed is to offer entertainment for one group of children, while another group is being screened.

Susan Gold reported about a fax she received from Lillian Poms which included a reply to a letter she wrote to the White House commenting on the President's Children's Initiative. She was concerned that there wasn't enough about children with special needs included. The reply is several pages long and Dr. Gold advised she would make copies available for the committee members.

Meeting Adjourned

Minutes respectfully submitted by:

Michele De Nisco Scott

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